Transcript
Transforming Patient Care: Aligning Interprofessional Education with Clinical Practice Redesign
2013 Macy Conference Recommendations

Moderator:

Please stand by. We're about to begin. Good day everyone, and welcome to the webinar on the Macy Conference *Transforming Patient Care: Aligning Interprofessional Education with Clinical Practice Redesign*. Today's call is being recorded. At this time, I'd like to turn the call over to Dr. Thibault. Please go ahead.

Dr. George Thibault:

Thank you everybody who has signed on for this webinar who is either looking at it on the web or is listening on the phone. We've been very heartened by the high level of interest in this. I will be joined on this call by Dr. Mary Naylor, professor of nursing at the University of Penn School of Nursing and by Dr. Malcolm Cox, who is the Chief Academic Affiliation Officer for the Veterans Administration Healthcare System. Mary and Malcolm were the co-chairs of this very important Macy Conference. And I'm going to just spend a few minutes at the beginning introducing people to the mechanism of the conference, how we arrived at these recommendations and a little of the background information that led us to have the conference in the first place. And then Mary and Malcolm will take us through the recommendations. We'll then have time for questions and responses.

The conference followed a format that is typical for a Macy Conference. We draw together thought leaders from around the country. In this instance, we had 39 educators and practitioners representing multiple professions from diverse institutions nationally. The list of those people is available in the conference report, which is on our website. We commissioned one paper to be a framing paper for the issues we were going to discuss, and then we commissioned five case studies from health care systems around the country that were illustrative of some of the early work in the areas that we wanted to emphasize. We then had three days of structured discussion in both plenary sessions and breakout groups leading to consensus recommendations. Following the conference, those recommendations are refined by a planning committee. They do represent the consensus of all the conferees, but it's not necessarily unanimous on every point. But every member of the conference participated in the process and reviewed the final product before its publication earlier this month.

The setting of the conference, as I think all of you were on this call will appreciate, is that this is a time of mental change in the health care system. Redesign of health care delivery and redesign of health profession education are occurring in parallel, but it was our observation that they are in parallel and independent, and there is an urgent need, which is why we came together as a conference, to link delivery and education reform if we are to achieve the triple aim of better care, better health and lower cost. Interprofessional education, which the Macy Foundation has helped to lead the effort nationally, and collaborative practice, which are part of the redesign strategy in many health care systems, we believe must be seamlessly joined to produce an environment in which all participants are learning, all participants are teaching, all are caring, and all are collaborating. This will require structural and cultural change to foster mutual respect across the professions and to facilitate the full engagement of patients, families, and communities served.

The conferees were unanimous on feeling that our vision for a health care system of the future is one in which learners and practitioners across the professions are working collaboratively with patients, families, and communities and with each other to achieve the triple aim. We see that there's a common purpose to both education reform and delivery reform and that common purpose is the improvement in patient care. That education reform must be informed by what is going on in delivery reform and delivery reform must include the obligation to participate in the education of the next generation of health professionals. It is that set of core beliefs and that common vision that led our conferees to a set

of recommendations that will move us towards achieving this vision and achieving these goals. And Mary and Malcolm will now take you through the recommendations starting with Mary, taking us through the first set and then moving to Malcolm. Mary?

Dr. Mary Naylor:

Thanks, George. I'm delighted to be with all of you and want to acknowledge right at the outset how thrilled I was to be with my wonderful colleagues, George and Malcolm, an outstanding planning committee and conference group, in developing these recommendations on this critical area. The first of the recommendations places a center spot on what is in the national discourse in health care redesign, the critical importance of engaging patients, families, and communities in the design, implementation and improvement, and evaluation of efforts to link interprofessional education and collaborative practice. We thought about engagement as a deliberate and consistent effort by all health care professionals to really place a spotlight on the central role of patients, families, and communities in defining what matters to them in promoting informed and shared decision-making and fostering shared accountability and assuring the kind of reciprocal and trusting relationships that are so important.

The importance placed on engagement was grounded in our understanding of the evidence that really helps us to know that incorporating patient preferences is contributing to higher value health care. We also believe that value is enhanced when patients and families and communities assume increased responsibilities for factors influencing their health. So let me now share with you some of the strategies that we thought about in terms of advancing increasing patient engagement, family caregiver engagement, and community engagement. We thought it was important that a national group be convened to identify effective methods for engagement in all parts, in all dimensions of linking interprofessional education and collaborative practice. Ideally, this group would be convened by public partners, private partners, would be informed by the work of national groups such as PCORI, the Patient-Centered Outcomes Research Institute, as well as by local, regional and national health care systems that really understand what it takes to deliver team-based care, and that ultimately, we would engage professional associations, educational institutions, and others in disseminating the results.

We certainly think that the expectations of patients, families, and communities are needed to inform the competencies that we use to guide the development of new models, linking collaborative practice and interprofessional education. We recognize that much has already been accomplished in delineating the aims of health care through the Institute of Medicine and that competencies for interprofessional learning and team-based care have been developed through groups such as the Interprofessional Education Collaborative. We now are at a point where we can build on this strong foundation by delineating those competencies that are informed by patients and families and communities. Our next recommendation really highlights the urgent need to accelerate the design, implementation, and evaluation of innovative models linking interprofessional education and collaborative practice. Conference attendees acknowledged that we have early innovators in this area who are designing such models.

All also agreed that these models could serve as prototypes for launching and testing new ones and that lessons learned in this process need to be rapidly disseminated. To achieve this recommendation, we believe that there should be broadly based coalitions to align education and clinical practice. These coalitions can help inform the operational design of the education practice interface and we believe government agencies, private foundations and others can facilitate their creation. We believe the National Center for Interprofessional Education and Practice would be an appropriate locus for much of this work. We also talk about how it is that we could accelerate areas by scenario-building. Scenario

building processes can assure a carefully constructed design of innovative models and also maximize on the use of finite resources. The scenario-building can start with a shared vision around the core values of achieving the triple aim through interprofessional education and practice. And certainly we believe in the importance of metrics.

Right now we have a paucity of rigorous evaluation methods. We need new scholarship to help design and test new metrics that link interprofessional education and collaborative practice to the goals of the triple aim. We certainly can value and build upon that which is known about the impact of teamwork on outcomes from other fields such as business and education. And we finally believe that our current academic institutions need to recognize the importance of this work, the scholarship, in the way that they allocate resources and in their promotion policies. So now let me turn to my dear colleague Malcolm, who will take you through the next set of recommendations.

Dr. Malcolm Cox:

Thanks Mary. I echo your introductory comments and would only add my thanks to the Macy Foundation for actually sponsoring this. This is a very important conference that relates exactly to where we are in thinking about both clinical delivery reform and education reform at the moment. The third recommendation was to reform the education and here's the important part, and lifelong career development of health professionals to incorporate interprofessional learning and team-based care. All too often we function on the early part of the educational pipeline and don't focus sufficiently on the rest of a health professional's career. So we were very careful to link those together. This recommendation was based on the rationale that unless there is an alliance of education and practice, it will be impossible to prepare the health professional workforce for collaborative work, be it learning or team-based care, which of course go along or hand in hand.

As I mentioned, we felt that there must be a serious effort to cover the entire continuum of formal education and continue for a professional lifetime. We felt that professional development must become a shared responsibility of educational institutions and health care delivery systems. Neither alone can effectuate this task. Both partners in this enterprise must jointly create learning environments and teachers that model interprofessional collaborative practice. Now, there were three sub recommendations to this and the first of those relates to... Actually four, excuse me, four sub recommendations or strategies. The first was to incorporate interprofessional team-based competencies into all health professions education programs. So that here we were thinking about adopting or modifying existing competencies, for example, the IPEC competencies and of course the task of creating additional or new ones. We were also thinking about the need to incorporate into regulatory standards these competencies.

The incorporation into regulatory standards would need to include education accreditation bodies and of course, delivery accreditation bodies. In the first category, perhaps the ACGME, in the second, perhaps the joint commission. The second strategy was to expand faculty development programs to prepare health professionals for effective interprofessional learning, teaching and practice. And this strategy was predicated on the fact that there are currently few existing role models and mentors for this task. So, the generic faculty development around interprofessional education and team-based care is an enormous task that is central to the mission that the conferees were creating. It would require broad expansion of the very small present efforts that are underway. The third strategy was to incorporate interprofessional team-based competencies in performance reviews of health professionals in clinical and academic settings. And here this strategy was predicated on the fact that institutional,

professional and government regulatory and licensure review processes would have to be subject to extensive study and review for this to be effective.

These performance reviews should be incorporated formally into faculty performance feedback systems of the future. And the last strategy was of course to develop new models of clinical education to prepare health professionals for team-based care. It's a sad fact that many of our models across all of our health professions at the moment of clinical education avoid in a large fashion or sometimes even completely, the need to prepare professionals for team-based care, the model of the future, so that we'd need new models that emphasize, for example, continuity of learning and caring in teams. The fourth recommendation was to revise professional regulatory standards and practices to permit and promote interprofessional education and collaborative practice. So, in this we were focusing on regulatory standards, and you all know the complexity of dealing with changes in regulatory standards. But the rationale here was that presently good teamwork and interprofessional collaboration are the exception rather than the norm and we need to make that the norm.

The professional regulatory system writ large, the entire system or systems must be revised to reflect the goal of interprofessional education and collaborative practice. The strategies that fall under this recommendation were three in number. The first focuses on accreditation and certification standards, and the idea here was to work on eliminating barriers to efficient and effective team-based care and clinical interprofessional education. This was predicated on the vision that health professionals should be able to teach students based on their areas of expertise and scopes of practice rather than solely on the basis of professional background. It's a very far-reaching recommendation. The second strategy was to revise state and federal laws and regulations to eliminate barriers to efficient and effective team-based care. This strategy was predicated on the fact that there really is an urgent need for collaboration across the professions to update state licensure practice acts and scope of practice regulations.

Of course, as part of all of this, there would need to be appropriate attention to the additional obligation of state licensure boards to meet the obligation of protecting the public. This was not to supplant that, but an addition to the core reason of their existence, which is protecting the public. The third strategy was to create incentives for institutional privileging policies that support linking efficient and effective team-based care and clinical interprofessional education. So here we were thinking around issues such as the following; that restrictions that artificially limit patient and learner access to the full variety of health professionals qualify to provide care, inhibits innovation in team-based care and interprofessional education. We were thinking that a series of incentives would probably be necessary. That would include things like the adoption of non-exclusionary privileging policies by accreditors such as The Joint Commission or payers such as Medicare.

Recommendation five, the last recommendation was around resources. I know you've all been wanting to hear about resources because it's important to figure out how we're going to fund this and I think we have some novel approaches to this. So recommendation five is to realign existing, hear the emphasis I put on existing, resources to establish and sustain the linkage between a professional education and collaborative practice. It was a consensus of the group that the chances of getting significant truly new money to do anything like this in the health care system probably did not exist at this constrained budgetary time. So the thinking here was that human and financial assets available for change are presently widely scattered, and poorly coordinated. The conferees felt that there was, in all likelihood sufficient money in the system, but there needed to be a cohesive effort to bring the different buckets of money and other resources together.

By doing that to create an effective, efficient and sustained linkage between IP and collaborative practice, will acquire all of the assets be brought to the table and shared in a rational fashion. Clearly

new payment systems will be needed to motivate participants engaged in system redesign. Clearly training and retraining in systems-based practice performance improvement and public health, all conspicuously underrepresented in the education of most health professionals today, will also be required. But most important, what is needed for this recommendation to have any traction is the substantive engagement of health system executives, educational leaders, insurers, professional organizations, and patients and communities. All of that engagement is essential. There were three strategies here that I'll end up with around this complex resource issue. The first was to delineate, identify, catalog, whatever the right word is, the resources presently or potentially available for support in the linkage of interprofessional education and collaborative practice.

An environmental scan or really a series of local, regional and national environmental scans needed to be done to identify all the appropriate health system assets and all the appropriate education system assets to be put on the table where everyone could talk about what they were, who owned them, how they could be reallocated with the goal of achieving the triple aim. The second strategy was to develop new models of resource-sharing among organizations that integrate interprofessional education and practice. Clearly, simply getting the buy-in of the leadership is necessary but not sufficient. We need new ways of shared governance, new models of shared governance, organizational management, and most importantly, new models of accountability. There will inevitably need to be, the thinking was, resource reallocation between educational and practice partners.

Not from one to the other, but a real, true melding of the resources, a bi-directional interchange of the resources, and that the alignment of incentives for those engaged in care provision and workplace learning should be focused around the collaborative achievement of the triple aim. Not the triple aim achievement by the delivery system or by parts of the educational system, but a collaborative achievement to achieve the triple aim. And the last strategy, which I think is a fairly obvious one, is with that as background, clearly each of these groups of partners coming together would need to demonstrate a positive value proposition for linking interprofessional education and practice, why it makes sense in their environment, why it might make sense nationally so that there would be individual value propositions. They might vary from one part of the country or one local area to another, but an effective business case including a positive return on investment and a plan for continuous improvement over time was thought to be essential.

Finally, I think the conferees agreed wholeheartedly with the fact that in this era of constrained resources, an effective business case will generally require reallocation of resources from programs not adding value and providing some upfront investment that can then be recovered from achieving the triple aim. So those were the three major recommendations of the five that the conference came to. And I think I'll pass this back now to you George for questions and discussion.

Dr. George Thibault:

Thanks, Malcolm and thanks Mary for an excellent summary of several days of needy discussion. We were very impressed that as complicated as these issues are and as diverse our audience was representing very different points of view across the spectrum of educational institutions and health care delivery, that we came to consensus on these issues, I think a strongly held consensus in a sense of urgency. The contrary is do not underestimate the degree of difficulty of pulling this off, but at the same time felt there was great urgency and that this is a very, very special moment, a propitious moment because so much change is actually going on that we seize this moment to direct the change in the most constructive way. Education can't change separately, and delivery system can't change separately, but they need to change together, and that was really the strongest of the common messages.

So we'll open it up now to questions and I think people have been instructed of how they would indicate and Robbie will call the order and we will direct the questions to one of the three of us.

Moderator:

Thank you. If you would like to ask a question, please signal by pressing star, one on your telephone keypad. If you're using a speakerphone, please make sure your mute function is turned off to allow your signal to reach to our equipment. Again, press star, one to be placed into queue. Now we'll go first to Maddie Schmidt with University of Rochester.

Maddie Schmidt:

Hi, thank you to both Mary and Malcolm for this terrific presentation and to Macy Foundation for its continued leadership in this area. I'm struck by the fact that these are pretty much emphasizing national recommendations and I'm concerned with the students that I teach that they can't really move forward until a lot of these national pieces are put in place and I'm constantly challenging them to see the relevance of this to the change that they can begin at the local level. I'm wondering if you could offer some examples of steps that can be taken at the local level now because obviously, we don't want to wait for all these changes to occur. That's the first part of the question. And then the second part would be, so if this change is going on at the local level, how would those folks know that things were moving in the right direction?

Dr. George Thibault:

Great questions, Maddie. Mary, do you want to take a first crack at the that?

Dr. Mary Naylor:

Hi Maddie, we probably didn't stress enough that we believe very much, and a great part of our conversation was focused on local solutions complimented by the kind of national energy that will be needed to move these solutions to all communities and make it a part of the fabric of the way we think about system design. So let me start by saying that I think it is critically important that we think about how to build coalitions that include your students, that include representatives of patients and family and community groups, that include leaders of our academic health centers, community health organizations, bring them all together around a table to begin to think about locally what is their shared vision? What is it that they believe is possible in their community to address most effectively their community's needs and that can be accomplished by linking interprofessional education and collaborative practice?

I think that getting to that shared vision will not be easy and maybe some of the other strategies that we proposed here might help guide that. I mean, if you thought about the kinds of scenario-building, for example, that helped to say not only what will this look like, what will this environment look like, but what might be some of the measures of success? You also might think about some of the case studies, for example, that we heard about who are already innovators out there, what can you learn from them? Once you've defined your vision at a local level, who are the exemplars that you could call on that align with that vision so that you can begin immediately to say, well these are some of the lessons learned, this has been a learning impact of what other innovators have done, these have been if they have them, some of the demonstrated impact on health or on costs? So I think that those are some initial steps, but I think they all start with getting around the table representatives from all groups and beginning to work on that difficult but important shared vision.

So then if you were to say, what would it look like five years later? I think success could be measured if you have at least one, perhaps more models that have successfully linked interprofessional education and collaborative practice that you have begun through maybe a collaborative to share the experience from successful models with each other and begin to see some of the spread, I certainly think that you should be seeing impact in terms of measures of students saying not just have I learned about what team-based care has done, but I have seen how it influences because we now engage patients and families and communities, their care, their experience. I certainly think that patients and families and communities should be able to communicate that they are benefiting from the fruits and gifts of what different interprofessional teams bring to the practice environment and do to influence their outcomes. So I hope that that begins to respond to the questions. Great questions. Thank you.

Dr. George Thibault:

I would just add to that excellent answer. In the preamble of our report before getting to the recommendations, it was acknowledged that while full implementation of these changes will involve action that may be well beyond the scope of any given educational institution or delivery system, that there is much that can be accomplished today at the local level by this engagement, and I see this happening around the country. We in fact commissioned five case studies that will get published in the monograph of the meeting that will be out in about a month. And those case studies highlighted activities going on at Geisinger, at Group Health of Puget Sound, Kaiser Permanente, the VA system, and the University of Minnesota as just examples of this kind of local activity. So there is much that can be done that does not require regulatory or payment change, but it requires leadership at the local level and we've seen enough examples to know that it can happen.

Dr. Malcolm Cox:

Maddie, it's Malcolm. I just want to piggyback on this because I think you raise a really critical issue. One can become paralyzed by thinking about the need to change from the top down. And yes, there is some need for change from the top down, but since I spend most of my time in Washington, I've been contaminated by politics and I really think that Tip O'Neill's old victim that all politics is local, applies here. National transformation in essence is going to be an aggregate of local changes. So I think you're dead on with focusing on the local changes. There are now, as I think you know and many others know now, the beginnings of the seedlings growing in the fertile soil. There's a lot of local change happening and I think we need to do this in large part from the bottom up rather than from the top down. Although both strategies are going to be necessary.

Maddie Schmidt:

Yes, I think that's extremely important and we're talking about local leadership. My experience is that you need to go back even further and that the students who are professionals, they're not pre-licensure students, these are people in practice that I'm working with now, have this mindset of the professional silo. So when I teach, one of my challenges is to push them and expose them to ways of thinking that get them out of their professional silos and to challenge them that the place they need to start is right in the place where they are practicing. Because often I get a response that, well, you're involved at the national level and you can make all those changes, but what can I do as a nurse practitioner in the emergency room or somebody in the community? My challenge to them is always that they need to start where they are and part of it is getting them to think differently.

Dr. George Thibault:

Great points, Maddie. Let's move on to the next question. Thank you very much.

Moderator:

Thank you. We'll go next to Scott Reeves with UCSF.

Scott Reeves:

Hi everybody, great report. I thoroughly enjoyed reading it and I think you make some excellent points. I just wanted to raise an issue about synergy across the systems which was mentioned today. I just wondered what kind of work do educational and practice institutions need to do with accrediting bodies to start revising their standards to meet the principles for effective interprofessional education and collaboration?

Dr. George Thibault:

Great question, Scott. Malcolm, you want to take a first crack at that?

Dr. Malcolm Cox:

Sure, I'll try to. It's a very important question. I've been in this game nearly 40 years now and I think it's only in the past three to five years that I've sensed a coming together of the thinking in at least many of our educational accreditation bodies around this issue. For example, the ACGME, which of course accredits graduate medical education programs, is changing its accreditation system, and some of the new standards and requirements in that deal with health, not just health care, but promoting health, population-based medicine, community engagement and so on, as well as systems-based practice. So I do believe that many, probably not all, and they're evolving at different rates, but I think I see for the first time around the country and I deal with a lot of these accreditation bodies across multiple professions given my role for the VA, they're beginning to see the light.

Another example related to that is the fact that the ACGME is putting in place in its new accreditation system, site visits that will involve meetings with the CEOs of the sponsoring institutions that will ask questions around the engagement of the institution in the community and so on. So I think there is already beginning slippage. I think as far as accelerating that trend, it's going to require all of us. When we've donned the hats of accreditors and many of us have a foot in both sides of the world so to speak, we've got to stop shucking our responsibilities that we're talking about today and bring those issues into the inner sanctum of the accrediting bodies and use our own internal and external bully pulpits to change.

For example, the VA is a national system based on aggregate of local systems and our leadership has become more and more outspoken about the need for accreditation, not just in medicine but nursing and other health professions to change so that the trainees that come to us, and there are 105,000 of those every year across 42 different health professions, are more functional in the kind of learning environment our health system is creating, which may be very different from the ones they're coming from. So I think it takes a lot of leadership work, but I do believe, Scott, the changes are beginning to accelerate.

Dr. George Thibault:

Thank you, and thanks Scott for that excellent question. We can go to the next question.

Moderator:

Absolutely. We'll go next to Tanya Uden-Holman with University of Iowa.

Tanya Uden-Holman:

Thank you. Well, there's been great discussion about some of the strategies that one can utilize to convince the leadership of one's university and academic health centers that IPE is really imperative in moving forward. But I was wondering if someone might be able to address what might be the tipping point or what do you see as those critical things to really help push us out of the silos that we currently have?

Dr. George Thibault:

Mary, you want to take a crack?

Dr. Mary Naylor:

I'll take a crack at this. I do think that the tipping point is going to be the evidence that we can produce that suggests, for example, that engagement of patients and families and communities gets us faster to higher value health care. I think we have some scholarships, some research that helps us to understand interprofessional the effects of teams. But I think what we quickly should do is place an unparalleled focus on getting the key stakeholders in this whole process, the patients and families and communities that we serve are fully, fully part of the team and quickly beginning to show how important that engagement is in changing our practices and in changing the way we prepare students to deliver those practices. So I think evidence and moving quickly on that evidence is the best path to take on.

Dr. Malcolm Cox:

Also, I would add to that more research and the more evidence, the better. But in addition to those necessary things, the students are your best advocates because it's been my experience. If you let them loose in an environment that may not be perfectly team-based or perfectly interprofessional, but if you show them, as Maddie was saying, if you show them that there's another way, they become incredible advocates and they allow you to just begin doing some of these things. I think the modeling at the local level is critical. In the VA models, we have five models around the country. For example, the students after just 18 months, the new pipeline of students, and here we're talking about internal medicine residents and nurse practitioner students, advanced practice folks are beginning to vote with their feet. They're beginning to demand of their dean that they want to be part of this experiment that they've heard about. The hospital directors are beginning to talk to us as educators, which is not an easy thing for a hospital director to do.

And they're beginning to realize the value added by having these industrious new teams, interprofessional teams working in at least the primary care environment. The academic affiliates, at least in two places, are beginning to adopt some of these models. So I think just doing it, the old Nike slogan, is very important too. You need these models to bubble up and the students in those models are going to be, I think, the best advocates and are going to allow those sites to develop the kind of evidence and to involve their communities in the fashion that Mary was talking about.

Dr. George Thibault:

Great. Thank you both Mary and Malcolm and thank you for that excellent question. Next question.

Moderator:

We'll go next to Anna Tresetter with Portland State University. It looks like she has disconnected. We'll go next to Tina Johnson with American College of Nurse-Midwives.

Tina Johnson:

Hi everyone, thank you so much for this wonderful report and for this forward-thinking. I'm really impressed with everything everyone's talking about here, it's really great. But I wanted to get back to resources and how we're going to deal with this on the local level. Like you were discussing before, many of our members are working on changing the barriers to practice at the local level and these mostly include removing unnecessary supervisory language that exists in various forms in different places. I'm from the American College of Nurse-Midwives and I'm sure my nurse practitioner colleagues can echo some of these concerns. But what we're finding is that when folks are trying to get the necessary changes made to do exactly what we're talking about here, they're getting so much pushback from a variety of organized groups and how do we really launch an effective campaign to even the playing field and include all the players like we're talking about, without an educational campaign targeted at the local level?

I really wonder what kinds of resources are being considered to educate legislators, the public and others to really say what we're trying to do here and explain why we don't need to have opposition to removing barriers that shouldn't be there in the first place and that will enable us to get to this wonderful place that we're all trying to go. What can we do? What kind of resources can we gather together to educate all those folks on the local level?

Dr. George Thibault:

Mary, you want to take a crack at that?

Dr. Mary Naylor:

Hi Tina, I totally agree that a premise of efforts to link interprofessional education and collaborative practice is that we come to a shared understanding of what it is that we are capable of contributing to that entire process. And I think the best opportunity for transformation is to bring the people that you're describing, the policy leaders to the table. They need to be a part of the process. It's going to take students, the kind of students that Malcolm just described, and patients and family caregivers, all of them working with leaders in health systems, in educational systems and the policy leaders at the table to come to that shared understanding that we cannot afford not to maximize on the contributions and gifts of everyone on the team to advance and accelerate the triple aim. So I think the best opportunity for transformation, I keep saying the best, or an opportunity for transformation here, is to bring them all to a part of that shared vision and not think that we're going to get it done and then convince policymakers as an afterthought.

Dr. George Thibault:

Go ahead Malcolm.

Dr. Malcolm Cox:

I was just going to say that recommendation one, which was the engage patients, families and communities in this effort was made recommendation one for a strategic reason. It's really the most

important recommendation. I think that Mary's dead on when she says that you've got to engage these people and they can work miracles if you get them engaged. And by engaged I mean put them on the boards of institutions, require that they be on the boards of institutions, put them on the boards of accreditation bodies. And that's beginning to happen already. ACGME has three or four public members now, and I am struck every time I go to one of those meetings by how they think differently than the professionals around them. And they're usually right on in their thinking. They keep us honest and they force us forward.

I can't emphasize enough how important it is to get your patients, your families engaged in this and the community engaged and certainly your trainees as well, absolutely critical. They will do things that we as more mature professionals perhaps have forgotten how to do well. So I would gather those people around you, and they have a lot better ideas than we do.

Dr. George Thibault:

I would agree with everything that's said. I think that we do need to create this groundswell of public demand for the most accessible, the most reliable and the most affordable care. And that can't be done absent using all of our health professionals up to their maximum training and qualification. The one other thing I'd say we've made a couple of mentions, but I would emphasize again the importance of having created a National Center for Collaborative Practice and Education and this issue of being a neutral convening ground and a public and policy educator is very much part of the agenda of that center, which was created by HRSA, federally funded, but supported by private foundations of which I'm proud Macy is one. This public-private consortium is also exactly the kind of model to bring about these changes. Federal government alone can't do it. Private action alone can't do it. But combined efforts of effective public-private partnerships can be a model. Let's move on to the next question. It was an excellent question.

Moderator:

Thank you. We'll go next to Kathy Chappell with ANCC.

Kathy Chappell:

Hi, thank you, this is Kathy. I'm the director of accreditation at ANCC, and I wanted to ask how you feel that accrediting bodies can continue to support interprofessional education in the collaborative setting. We are currently working with ACCME and ACTE and have developed the joint accreditation program that credentials organizations that do interprofessional education. So I was thinking those organizations might be great examples of which to draw models or outcome metrics related to interprofessional education.

Dr. Malcolm Cox:

I think that's an excellent model and there's no question that if that were expanded and enlarged that it would be even more effective than it is. It's still in its infancy obviously, but those are just the kinds of strategies and concrete strategies that we need. So I applaud that group for putting those organizations together.

Dr. George Thibault:

I agree. That's just exactly what we need. We need more of that kind of cooperative activity. I think various partners are going to help bring this about. I spoke previously about public-private partners, but we need cross professional partners and coming together with the idea that there actually is a better way to do it and the way that we've been doing it all along, just because we're familiar with it, doesn't mean it's the best way to do it. So I applaud the ANCC for that work and for their leadership in this. I think we have time for one or two more questions.

Moderator:

Thank you. We'll go next to Karen Holder with North Country HealthCare.

Karen Holder:

Hello, I'm Karen Holder and I'm a family nurse practitioner. I've been in practice for about 35 years and have done a lot of interdisciplinary precepting. I'm a clinician, a little bit of an educator, and I've been a part of a number of interprofessional educational agency models, including family practice in Worcester, Massachusetts, in the 1980s and have seen lots of models work at a clinical level. But my question is I'm starting one at North Country, which is in a rural area of Arizona, and we're collaborating with osteopathic medical students and nurse practitioner students to begin with, some clinical pharmacists as well. My question to the group or to the panel is about accessing resources. Because I'm not a researcher, I don't really have a grasp on how to develop metrics to measure the impact of our programs and wonder if there's help out there, if anything's been developed. I hear smatterings of it from people who have contributed already, but can you guide me?

Dr. George Thibault:

So I'll come back to the theme of partnering. There are some natural partners out there for you. HRSA is funding a program for training of rural nurse practitioners, and I know Arizona is one of the sites of that. There is a grant that Macy has given to Arizona State and the University of Arizona together to promote a model of interprofessional education to train health professionals in rural care and in primary care. So I would say look for partners. I agree with you, every site cannot create its own research enterprise, but the partners are there. I'd refer you to Gerri Lamb, a nurse at Arizona State who I think could help you connect with some of this very exciting activity that's going on in your state.

Karen Holder:

This is Karen again, it turns out that actually we are in collaboration working with some of the GNE funds that were granted for Arizona through St. Luke's Initiative. And we have an ASU student who's funded by the Macy grant. So I think what I hear you saying is just go to those institutes and ask them to help me with the research pieces.

Dr. George Thibault:

Right. Exactly.

Karen Holder:

Awesome, thank you. And if I could just jump in, for Mary with ACNN, the American Association of Nurse Practitioners is doing a lot of work on scope of practice and it's sitting at the table with a lot of

policymakers. You may want to visit their site, Mary, and just see the kinds of things they're doing and see if ACNN can collaborate with a AANP.

Dr. George Thibault:

Right. Time for one more question.

Moderator:

And we'll take that question from Jacqueline Owens with Ashland University.

Jacqueline Owens:

Well, thank you so much today for your time to help us understand all of the opportunities that we have with interprofessional education. My question is on the local level as well. I think about the challenges of IPE in rural areas where we're pretty geographically diverse and certainly we have clinical practice settings, but it's sometimes not easy to get many different disciplines involved in one educational initiative. So I'm wondering if you have any recommendations to encourage IPE in this kind of a setting. And specifically, are there any examples of someone doing this particularly well? I would be especially interested in hearing about use of some kind of virtual tools for communication. Thank you.

Dr. George Thibault:

So great question. Again, I referred to the program going on in Arizona, which is using telemedicine to try to extend its reach, and some similar work that's going on at UC Davis that I'm aware of. And then of course at the University of Washington, which has a 30-year-long program called the WWAMI Program in which they are connected to the five states of the northwest that don't have a medical school and have been providing a medical education, graduate medical education, and other health professional education across the large geographic area. So there are some models out there, and I would refer you to those institutions that are doing it using tools like telemedicine to extend the reach and to create, if you will, virtual interprofessional teams. I don't know, Malcolm and Mary, do you want to add anything? The VA has also done some innovative things, I know, to extend the reach of the VA to its far-flung patient population.

Dr. Malcolm Cox:

Yeah, there are people in Boise, Idaho, which you recognize although Boise is urban, the area it serves is very rural. And their nursing school partner is I think three or four or 500 miles away, which is Gonzaga. So they've done some telemetry work and have a good sense of the rural issues. But I think the real help is going to come from the HRSA National Center because one of their tasks, as I understand it, is to catalog and publicize all these little things that are going on. And the trouble that I think the last two questioners are having is you have some ideas, you've begun something, but you need to see who you can collaborate with. I think the HRSA Center as it gets up and running, is going to be terrific in publicizing and cataloging the opportunities. So I would very much stay in touch with that center and get on their mailing list. Barbara Brandt is the director at the University of Minnesota and get on their mailing list because you'll get a wealth of information from them.

Dr. George Thibault:

That's an excellent point, Malcolm, and I think that's a good point to end on. We think while we don't want to pretend the National Center is going to solve all of these problems, all of us have to participate in the solution. But its creation has given us a platform at a very important moment in time, it highlights how important this combination of interprofessional education and collaborative practice are that a federally funded national center was created. But it will be a resource and I would refer everybody to it. We will continue to promote its work. I want to thank everybody for their level of interest. I sense we could have kept going, but we promised this was an hour. We urge you to stay in touch with our website, to stay in touch with the website of the National Center. And we are very, very excited about this work and we will be continuing as a foundation to promote projects that support this work and to continue to use our convening function.

Finally, I want to thank Malcolm and Mary not only for their superb performance in this webinar, but for their leadership throughout this whole process of putting together a conference, conducting the conference, publishing its result. It's more than most people realize, and I'm sure more than they realized when they agreed to do it, but we wouldn't be where we were without them, without all the other people who participated in the conference. So thank you all very much and I think the final method, going back to Maddie Schmidt's first question, there's a lot everybody can do at the local level. I urge you to take these ideas back and try them out in your own environment and find your natural allies there to get this momentum moving. Thanks.

Dr. Mary Naylor:

Thank you all.

Moderator:

That does conclude today's call. Thank you for your participation.