

ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY

Interprofessional Education

**Tenth Annual Report
to the Secretary of the
U.S. Department of Health and Human Services
and to Congress**

July 2013

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The Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) is a Federal advisory committee under the auspices of the Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services (HHS). HRSA is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

HRSA's Division of Policy Information and Coordination coordinates advisory committee management activities for HRSA's 14 advisory committees and serves as the official liaison between HRSA and the HHS Committee Management Officer, Office of the White House Liaison, Office of the Secretary. Each advisory committee is managed by a Designated Federal Official, who is responsible for the committee's management and administrative matters. ACTPCMD's Designated Federal Official operates within the Division of Medicine and Dentistry, a part of HRSA's Bureau of Health Professions.

The views expressed in this document are solely those of the Advisory Committee on Training in Primary Care Medicine and Dentistry and do not necessarily represent the views of the Health Resources and Services Administration nor the U.S. Government.

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ADVISORY COMMITTEE ON TRAINING IN PRIMARY CARE MEDICINE AND DENTISTRY

The Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) is authorized by sections 222 and 749 of the Public Health Service Act (PHSA) (42 U.S.C. §§ 271a, 749), as amended by section 5303 of the Patient Protection and Affordable Care Act. The ACTPCMD originally was established under the authority of section 748 of the 1998 Health Professions Education Partnerships Act.

The ACTPCMD provides advice and recommendations on policy and program development to the Secretary of the U.S. Department of Health and Human Services and is responsible for submitting an annual report to the Secretary and to congress concerning the activities under sections 747 and 748 of the PHSA, as amended. Reports are submitted to the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Energy and Commerce of the House of Representatives. In addition, ACTPCMD develops, publishes, and implements performance measures and longitudinal evaluations, as well as recommends appropriations for levels for Part C of Title VII of the PHSA, as amended.

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VISION

We envision a health care system that cares for all patients within a patient-centered health home. The patient-centered health home involves a team of health care professionals providing coordinated, comprehensive care consistent with the core principles and values of effective team-based health care (Mitchell, P, Wynia, M, Golden, R, et al., 2012). The health home functions within a neighborhood that includes primary care and specialty/subspecialty practices (American College of Physicians, 2010). This model of care will require a primary care workforce that can operate as an interprofessional team relying on each discipline's licensed scope of practice. Primary care teams would involve an array of members (see Table 1), which may include but not be limited to:

- Lay health workers and community health professionals;
- Clinical professionals who provide or coordinate direct care to patients;
- Service personnel who provide infrastructure for care delivery; and
- Population-health professionals who address system-level performance.

We believe these teams are central to the goal of eliminating health care disparities and attaining accessible, high-quality, and affordable health care for all.

Table 1. Health Team Members

- **Lay health workers and community health professionals:** patients, patients' families, promotoras, community health workers, community agency personnel.
- **Clinical professionals who provide or coordinate direct care to patients:** nurses, advanced-practice nurses, medical assistants, physical therapists, occupational therapists, speech therapists, respiratory therapists, dietitians and nutritionists, procedure technicians, radiology technicians, behavioral and mental health specialists, social workers, health educators, home health aides, child life specialists, care coordinators and care managers, dental hygienists, dental health aide therapists, dentists, pharmacists, physician assistants, physicians.
- **Service personnel who provide infrastructure for care delivery:** laboratory technicians, health information technology staff, communication operators, receptionists.
- **Population-health professionals who address system-level performance:** patient safety, quality and performance improvement, public health and prevention, program planning and evaluation, health literacy and communication, community health assessment, cultural awareness and competency.

BACKGROUND

In its ninth report, *Priming the Pump of Primary Care*, the U.S. Department of Health and Human Service's Advisory Committee on Training in Primary Care Medicine and Dentistry (ACTPCMD) (2012) identified interprofessional education (IPE) as a central component of preparing a workforce that is fully able to address the primary care needs of the United States. That report noted:

Trainees in the various medical professions are typically taught in isolated silos, often inadequately prepared for working in an interprofessional team. Therefore, interprofessional education is a vital curriculum component to ensure that future medical and dental providers can engage in interprofessional practice upon graduation. However, the lack of understanding of each other's roles and lack of training in interprofessional collaboration among providers are key barriers to effective interprofessional practice. As noted in the eighth annual report by [ACTPCMD], members of teams must be trained together to fully function as interprofessional practice teams (Advisory Committee on Training in Primary Care Medicine and Dentistry, 2010). The inclusion of interprofessional education in training curricula would remedy this barrier with future medical and dental providers.

The ninth report included the following seventh recommendation:

The Advisory Committee recommends funding for training innovations that focus on competencies needed for primary care practice, including those related to population health, a public health perspective in clinical decision making, systems practice, and interprofessional collaboration.

IPE is not an end in itself but is one strategy to achieve the goals of (1) patient-centered care, (2) optimal care experiences for patients and their families, (3) patient safety, (4) improved quality of care, (5) enhanced health throughout the population, and (6) reduced costs of care. The value and success of interprofessional care is measured by how well it achieves these aims.

IPE presumes that the patient will be the central member of a care team, that professionals on the care team will have established separate and flexible role identities, and that team members will also have skills in patient engagement, shared decisionmaking, goal setting, care planning, motivational interviewing, quality improvement, and group process facilitation. Creating opportunities for interdisciplinary care and IPE requires institutional leadership to drive change at all levels, so a structured approach to leadership development is needed.

IPE and collaborative practice function operationally at the point of care, at the institutional level, and within the entire health care system:

- At the **point of care**, the patient is the center of the continually iterative processes of caring and learning, in settings where both practice and training take place.
- In **institutions**, practice redesign and education reform are mutually reinforcing activities.
- In the **health care system**, laws, regulations, accreditation, structures, and financing provide both barriers to and opportunities for IPE and collaborative practice.

IPE includes instruction about collaborative practice, instruction about specific content, and on-the-job training.

- **Instruction about collaborative practice** addresses the roles and functions of different health professions in patient-centered care, covering the four interprofessional collaborative practice competency domains:
 - The values and ethics of an interprofessional practice;
 - The practitioners' roles and responsibilities;
 - Interprofessional communication; and
 - Teams and teamwork.

(Interprofessional Education Collaborative Expert Panel [hereinafter, “IPEC”], 2011.)

- **Instruction about specific content** provided to multiple professions simultaneously is efficient and produces a secondary gain of IPE awareness, insight, and skills. IPE has demonstrated effectiveness in teaching quality improvement, patient safety, bioethics, and mass disaster preparedness (Conference on Interprofessional Education, 2012) while other topics may be desirable areas for IPE, such as critical care, chronic care management, geriatrics, end-of-life, human sexuality, oral health, and nutrition.
- **Workplace on-the-job training** and practice improvement projects address competencies needed for highly functional interprofessional work teams to focus on care processes for their daily clinical care of patients and the continued improvement of their performance.

IPE curricula include activities designed to impact learners, educators, and the clinical education environment, all of which are routinely mentioned in guidance materials the Health Resources and Services Administration (HRSA) distributes with funding opportunity announcements. Learners need appropriate tools, resources, and support to master IPE competencies and to apply them eventually in their practices. A robust mechanism is necessary to evaluate the curriculum and assess the achievement of competencies. These needs form the bases of the recommendations that follow.

Recommendations in the **Collaborative Interprofessional Education and Training** and **Assessment and Evaluation** sections below address the needs of learners. Educators need to develop specific skills to teach in interprofessional teams and to model and mentor best practices. Recommendations in the

Institutional Leadership for Interprofessional Education

section address educators. In-patient and out-patient settings for clinical education need institutional support for interprofessional teamwork among members of the workforce, and they need health system incentives, such as payment for interprofessional practice.

Recommendations in the Integration of Dental and Medical

Care Services section address advancements in dental education and practice. Recommendations in both the **Institutional**

Leadership and Interprofessional Education and the **Policy**

Development sections address the clinical education environment.

In summary, IPE is an educational strategy to train health professionals in collaborative, team-based care for a health system that is being transformed to eliminate disparities and to provide accessible, high-quality, and affordable health care for all (Conference on Interprofessional Education, 2012). ACTPCMD makes the following recommendations so that IPE can contribute to achieving the triple aim of (1) enhancing the patient experience of care (including quality, access, and reliability), (2) improving the health of the population, and (3) reducing the per capita cost of care (Berwick, DM, Nolan, TW, & Whittington, J, 2008).

RECOMMENDATIONS

Under section 747 of Title VII of the Public Health Service Act, HRSA provides grants and contracts that support training in primary care; section 748 provides similar incentives for programs in dentistry. ACTPCMD supports the recommendation from the Council on Graduate Medical Education (2010) that Congress restore and enhance funding for section 747 at \$560 million for the next fiscal year and ensure that this larger appropriation is distributed broadly across disciplines covered by the section 747 programs. In addition, ACTPCMD recognizes that the purpose of IPE is to prepare health profession learners with skill sets that achieve patient-centered care, the optimal care experience for patients and families, patient safety, improved quality of care, increased health throughout the population, and value. To achieve these aims, a receptive and supportive practice environment is needed, where interprofessional teams can function at their greatest capacity. If these critical success factors are not established, IPE will fail as a transformative innovation.

Within this context, ACTPCMD makes the following recommendations:

COLLABORATIVE INTERPROFESSIONAL EDUCATION AND TRAINING

Goal:

Title VII should promote interprofessional team-based training, integrated throughout the curriculum, through the use of innovative methodologies. As a result of experiential learning, trainees will demonstrate core competencies for collaborative practice and will become leaders in practice transformation.

Justification:

Primary care medicine and dental programs are looking to innovate around best practices and the production of best outcomes, and team-based care is an essential component of good patient care. New educational models are needed to define best IPE practices in health professions and to advance clinical practice.

Recommendations:

1. HRSA should support grants that are funded across divisions within its Bureau of Health Professions.
2. Title VII training grants should favor programs focused on learners achieving the core competencies for interprofessional collaborative practice outlined by the Interprofessional Education Collaborative (IPEC, 2011).
3. Title VII training grants should promote the integration of interprofessional competencies with discipline-specific established core competencies to ensure that interprofessional collaborative practice is part of the foundation for the training of all health professionals.
4. Title VII training grants should include a detailed description of the curriculum under consideration that:
 - Demonstrates the integration of interprofessional instruction throughout training and the inclusion of active experiential learning that assures the transfer of learning to clinical training and practice;
 - Includes a developmental perspective, linked to validated appropriate evaluation methods; and
 - Includes a detailed description of how the proposed instructional methods promote learning.
5. Title VII training grant education programs should employ models of team-based care, in a variety of settings, so that learners advance their mastery of the following areas:

- The patient and family as central members of the interprofessional team (Carman, KL, Dardess, P, Maurer, M, et al, 2013);
 - Patient behavioral change and self-management of the patient's own health;
 - Health literacy and patient education (a HRSA priority area);
 - Care coordination with the medical neighborhood and community agencies and services;
 - Population management, chronic care management, and patient engagement;
 - Public health and prevention within a community, and cultural context; and
 - Care for vulnerable populations (a HRSA priority area).
6. Title VII training grants should employ educational models and instructional methods that are innovative and use cutting-edge technology.
 7. Title VII training grants should identify and develop strategies to address barriers to IPE.

ASSESSMENT AND EVALUATION

Goal:

Title VII training grants should use formal evaluation methods to measure relevant educational outcomes and clinical performance domains, and they should work to develop novel evaluation methodologies using logic models. Disseminating the outcomes of programs will expand the knowledge base of IPE.

Justification:

There are no robust research results demonstrating which team models work best in which settings for particular patient

populations or clinical problems. Education science about the best methods for preparing interprofessional learners for collaborative practice is not well developed. Innovative instructional models likely will require new evaluation methods. Title VII training grants can address these critical gaps.

Recommendations:

1. Title VII training grants should employ metrics, both currently available and newly developed, to assess their learners' success in achieving IPEC core competencies. Evaluation methods should address the range of relevant educational outcomes and clinical performance domains.
2. Title VII training programs should emphasize the development of novel evaluation methodologies and new assessment techniques, capturing the complexity of IPE with qualitative and quantitative measures. Logic models should be employed to link interventions to short-, intermediate-, and long-term outcomes. HRSA should develop mechanisms for disseminating these new evaluation methods, such as through the new National Center for Interprofessional Practice and Education housed at the University of Minnesota (see <http://www.ahceducation.umn.edu/national-center-for-interprofessional-practice-and-education/>).

INSTITUTIONAL LEADERSHIP FOR INTERPROFESSIONAL EDUCATION

Goal:

Tailored leadership development should be provided to stakeholders at the national, regional, institutional, academic, and service delivery levels to advance IPE among all health professions

and, in general, to advance collaborative practice throughout health care delivery.

Justification:

Creating a primary care workforce to function in interprofessional teams will require that academic leaders develop new educational programs for training health professionals and that clinical leaders develop new service models and settings for both training and effective team practice. The transformation of education and practice will be advanced as trainees become change agents.

Recommendations:

Leadership development, in the form of Title VII training programs, should:

1. Engage administrators, regulators, accrediting bodies, professional organizations, community members, academicians, providers, staff, and patients in the development and implementation of the programs.
2. Educate participants in leadership development programs about the roles and responsibilities of members of the primary care team and the development of effective, innovative models of interprofessional practice.
3. Encourage leaders to embrace interprofessional practice in their clinical settings, lead system change to support collaborative practice, and include trainees in their innovation strategies.
4. With interprofessional teams of faculty educators, develop core curricula and instructional strategies that provide leadership training opportunities at all education levels in all health professions.
5. Model IPE by delivering instruction using interprofessional teams of educators, such as the Smiles for Life Curriculum

from the National Interprofessional Initiative on Oral Health (NIIOH) (Clark, MB, Douglass, AB, Maier, R, et al, 2010).

6. Prepare trainees to become agents for change by providing these learners with instruction on change management, mentoring, and guided leadership experiences.
7. Create academic pathways to promotion based on IPE, including teaching and evaluation, research, leadership, and enduring materials.
8. Establish a logic model for the longitudinal evaluation of leadership development, and institute data collection and analysis to be used for program improvement. These practices should lead to:
 - Timely feedback to individual programs in order to improve quality; and
 - Informed program development at the HRSA level.

INTEGRATION OF DENTAL AND MEDICAL CARE SERVICES

Goal:

The separation between oral health and systemic health does not serve the needs of patients. There must be a mutual interaction between oral health and systemic health using efficient interprofessional communication. HRSA grants should foster initiatives that bridge interprofessional communication between dentistry and other health professions.

Justification:

To achieve integrated health homes for patients, dental training programs and practices should interact and integrate more effectively with medicine and other health professions in terms of educational content, quality measures, and health information systems. Available national dental quality indicators are ill-

defined, overlapping, or not standardized. Inadequate infrastructure exists for patient health information in electronic health records (EHRs) to be shared in practices that link medical and dental care delivery.

Recommendations:

1. Title VII grants should favor dental teaching institutions that:
 - Move toward integrating basic science education for dental and other health profession students, such as shared classes or online education; and
 - Provide dental and other health profession students with integrated clerkships or equivalent experiences in relevant clinical settings, including hospitals, nursing homes, ambulatory care clinics, dental clinics, and other settings (Institute of Medicine, 1995).
2. Title VII grants should promote integration and quality improvement initiatives that build linkages between primary care medicine and dentistry, including a common EHR system and billing language that could promote diagnostic coding with quality indicators for both medical and dental practice.
3. Title VII grants should favor dental teaching institutions that promote a focus on diagnosis, science, and being more involved in systemic aspects of patient health (Powell, VJH, & Din, FM, 2012).
4. Title VII grants should favor institutions that develop methods for the use of evidence-based applications that will become critical steps in moving dentistry and primary care medicine toward the adoption of interprofessional applications and standards.

POLICY DEVELOPMENT

Goal:

Policy development by agencies and individuals outside HRSA will significantly affect progress in interprofessional collaborative practice. To effectively promote team-based health care, HRSA and appropriate agencies should address accreditation and certification criteria related to IPE and collaborative practice. Title VII grants should encourage education about policy issues central to IPE and collaborative practice.

Justification:

Accreditation programs that determine the content and structure of training efforts will have a significant impact on the success of IPE and will need to be involved early in IPE efforts. State-controlled medical liability laws that place risk on individual providers and health care institutions do not support the shared medical liability necessary for team-based care. HRSA and Title VII grantees and their learners will need to support policy changes necessary to advance IPE and collaborative practice.

Recommendations:

1. HRSA should convene leading accreditation and credentialing bodies to assist with modifying their accreditation and/or credentialing criteria to include IPE competencies.
2. Health profession schools and training programs should ensure that risk management is a part of the core competencies of interprofessional education.
3. Health profession schools and training programs should ensure that risk management protocols are set and followed in the clinical settings used for education and training.

4. Title VII grants should favor funding for institutions that include instruction about health policy related to IPE and collaborative team practice.

CONCLUSION

Interprofessional collaborative practice can contribute to the improved health of U.S. citizens by (1) enhancing the patient experience of care and improving quality, access, and reliability, (2) improving the health of the overall population, and (3) reducing the per capita cost of care.

ACTPCMD's recommendations address the multilevel approach necessary to ensure the successful training of the health profession workforce needed for patient-centered health homes. Collaborative training and education requires the development of innovative models, along with a robust assessment and evaluation system. Institutional leadership support, including faculty and staff development, is necessary for these programs.

Support for integration of dental education and practice with other health professions is critical to the success of interprofessional programs and should be bolstered.

Investing in IPE is a pivotal step in achieving the highest quality training for health professionals to provide team care in the United States. ACTPCMD strongly urges HRSA to support the development of IPE to move closer to the overall goal of eliminating health care disparities and attaining accessible, high-quality, and affordable health care for all people.

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