This is the fourth module of the HHS Education & Training Curriculum on Multiple Chronic Conditions (MCC)—a six-module curriculum designed for academic faculty, educators and trainers to inform healthcare professionals caring for persons living with multiple chronic conditions. Based on the MCC Education and Training Framework (http://www.hhs.gov/ash/initiatives/mcc/education-and-training/index.html), these modules provide knowledge and tools healthcare professionals can use as they improve quality of care of persons living with MCC.

Terminology used throughout this presentation:

- Multiple chronic conditions (MCC) is defined many ways in the literature and in practice. For the purposes of this presentation, MCC is defined as a person with two or more concurrent chronic conditions. Other similar terms used are complex patient, multimorbidity and comorbidity for this population.
- "Persons living with multiple chronic conditions" (PLWMCC) is used instead of "patient" to place greater emphasis on the individual being at the center of care.

Each module has a PowerPoint® slide presentation that can be saved, modified, and used in your presentations with health professionals at any stage of education (undergraduate, graduate or continuing education). The notes in the presentation will help guide your talking points during the presentations.

Visit http://www.hhs.gov/ash/initiatives/mcc/education-and-training/index.html to download this and other modules—and to access helpful tools and resources.

Suggested citation:
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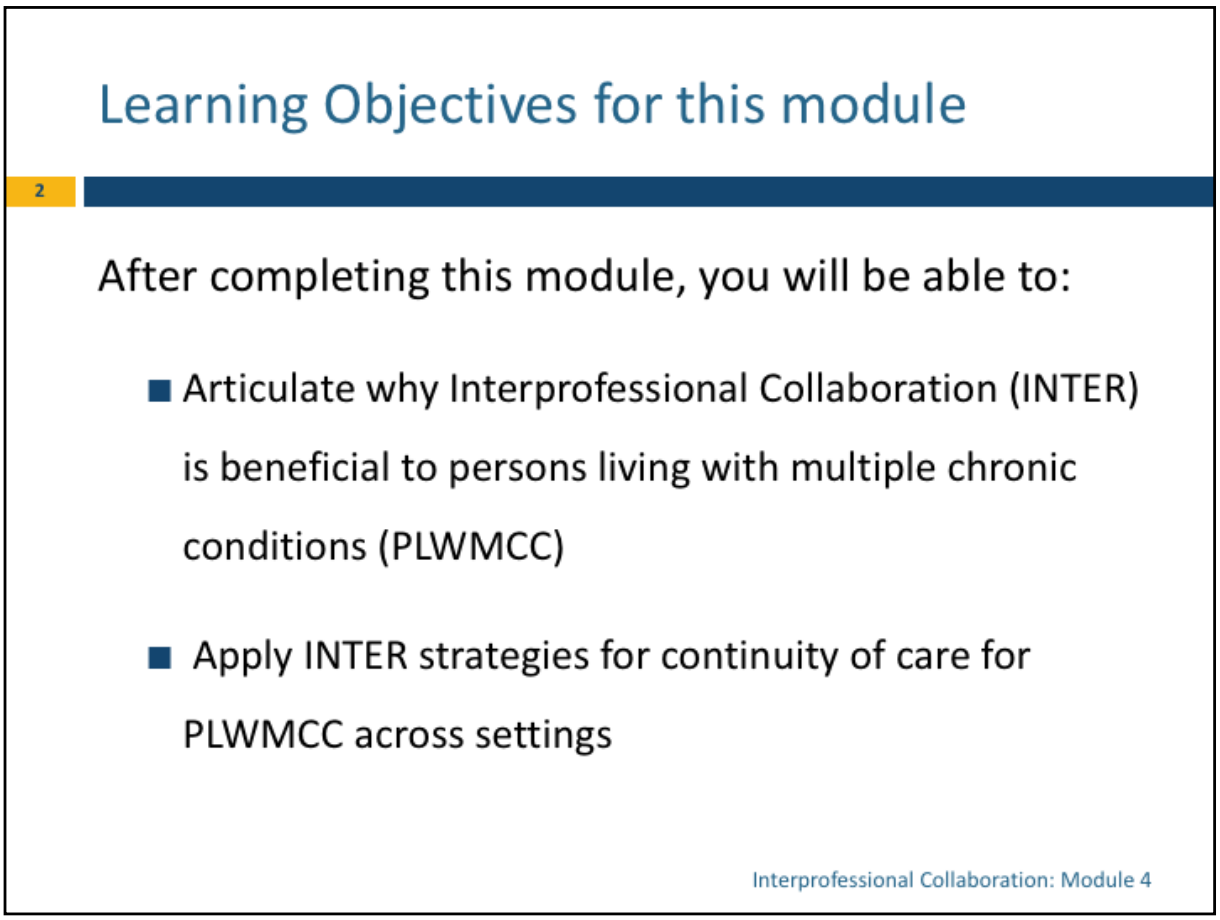
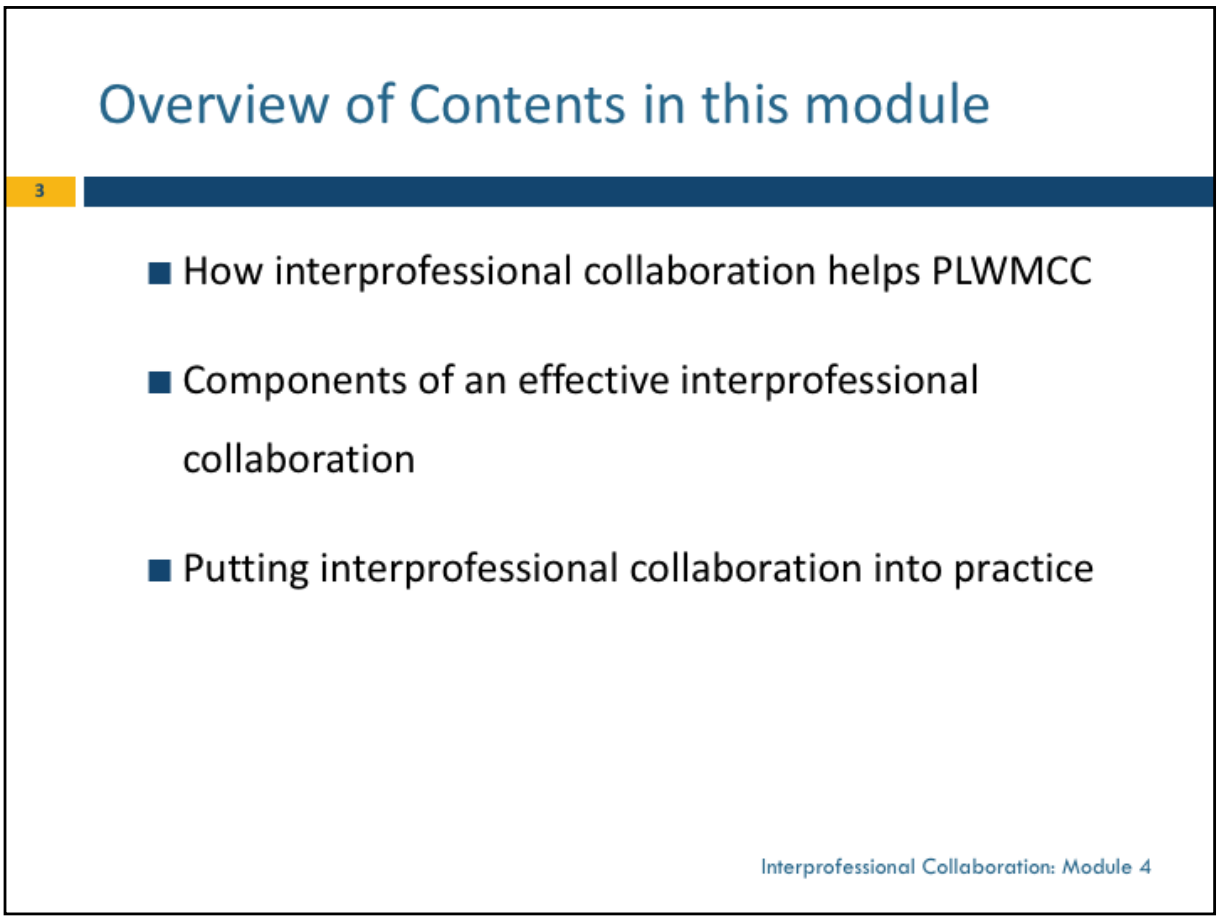
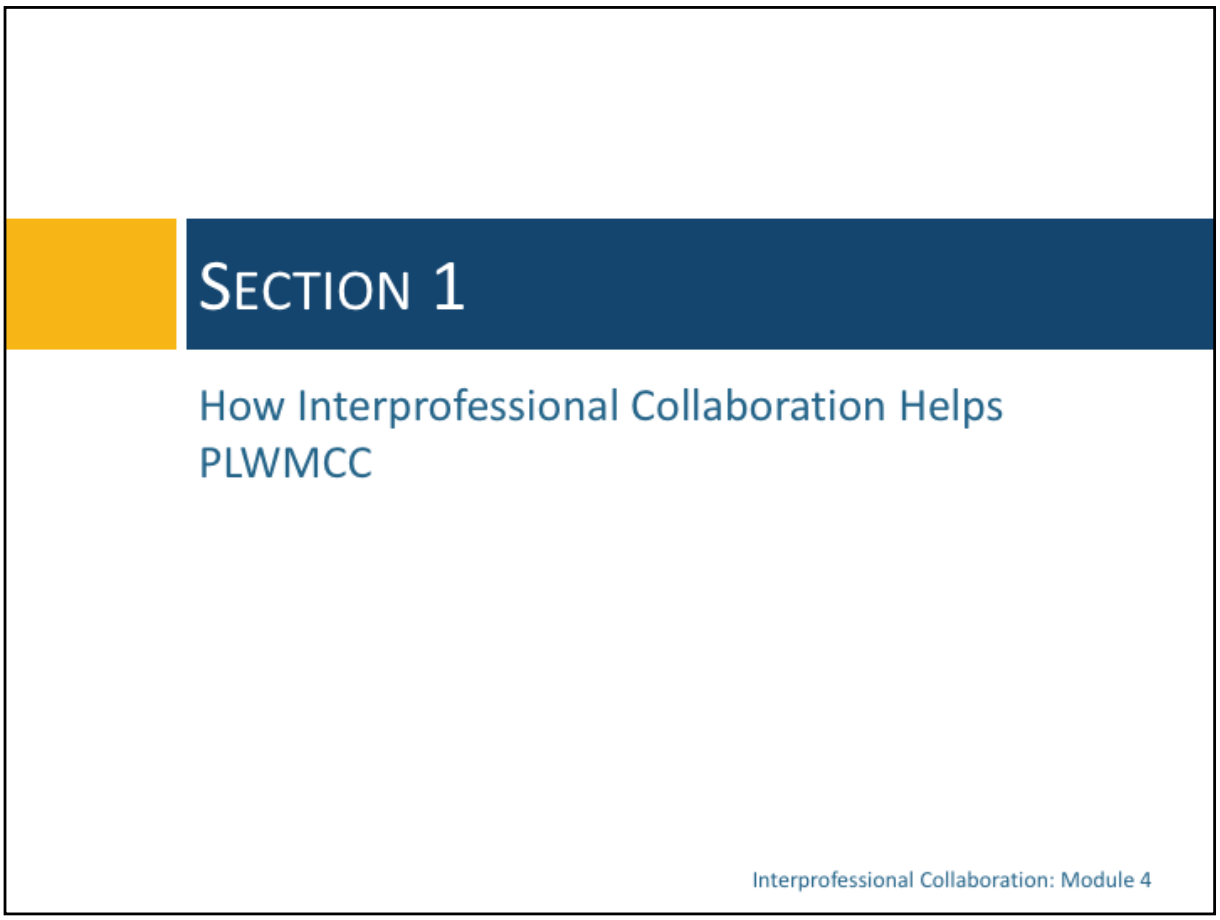


This module, "Interprofessional collaboration" of the MCC curriculum provides:

1. An overview of interprofessional collaboration as an effective mechanism for healthcare professionals to help people manage their multiple chronic conditions, and;
2. Practical strategies and resources for integrating interprofessional collaboration into practice.



This module is divided into three sections: How interprofessional collaboration helps PLWMCC, components of an effective interprofessional collaboration and putting interprofessional collaboration into practice. These modules address interprofessional collaboration components, strategies and tools to better help you care for persons living with multiple chronic conditions.



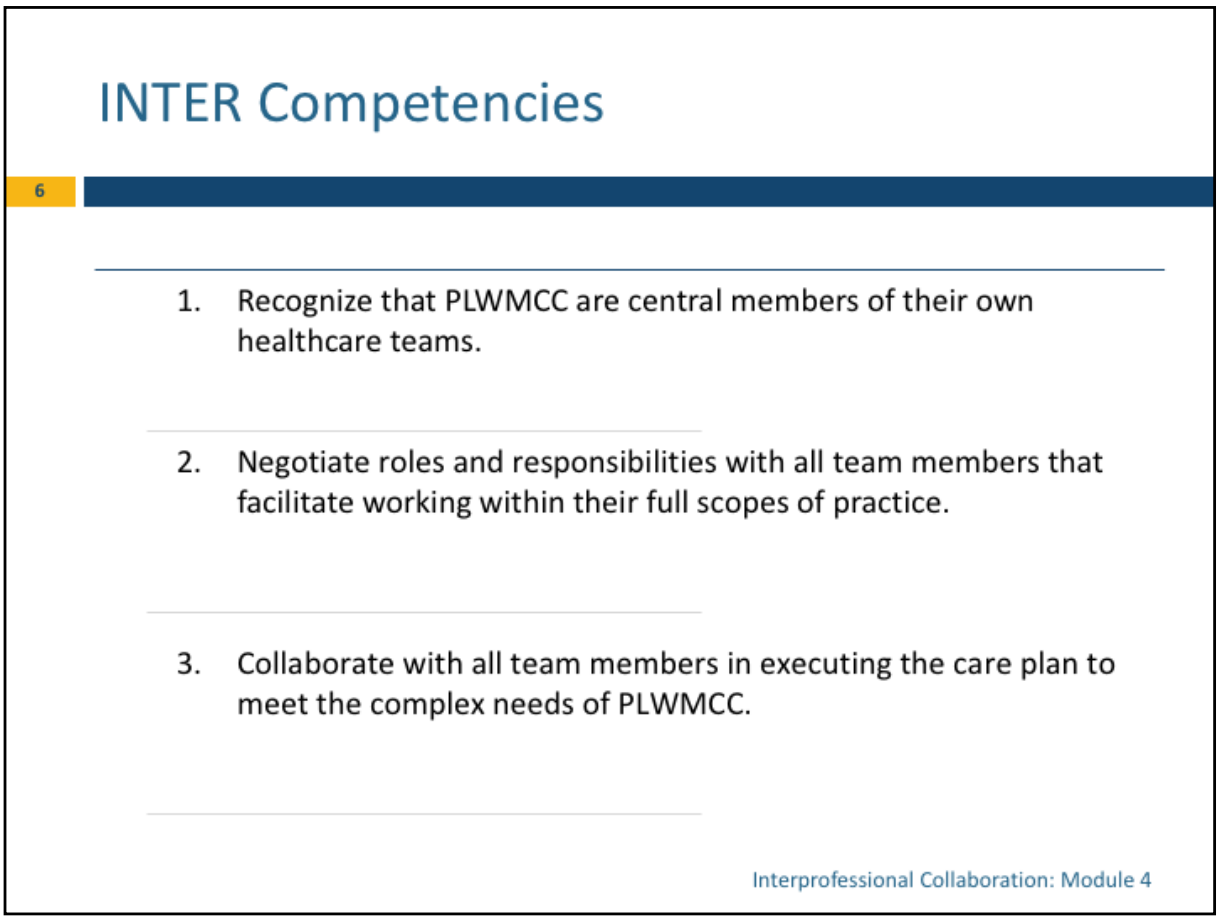
This section will define Interprofessional collaboration, identify key INTER competencies to care for PLWMCC and the benefits of INTER for clinicians and PLWMCC.

The ability of healthcare and other professionals, as well as direct care providers, community health workers, PLWMCC, families and caregivers, to work effectively within and between professions and with persons living with MCC (PLWMCC), families, caregivers, and communities[1] to provide appropriate and effective healthcare.

References:

1. Schmitt, M., Blue, A., Aschenbrener, C. A., & Viggiano, T. R. (2011). Core competencies for interprofessional collaborative practice: reforming health care by transforming health professionals' education. *Acad Med, 86*(11),

1351.



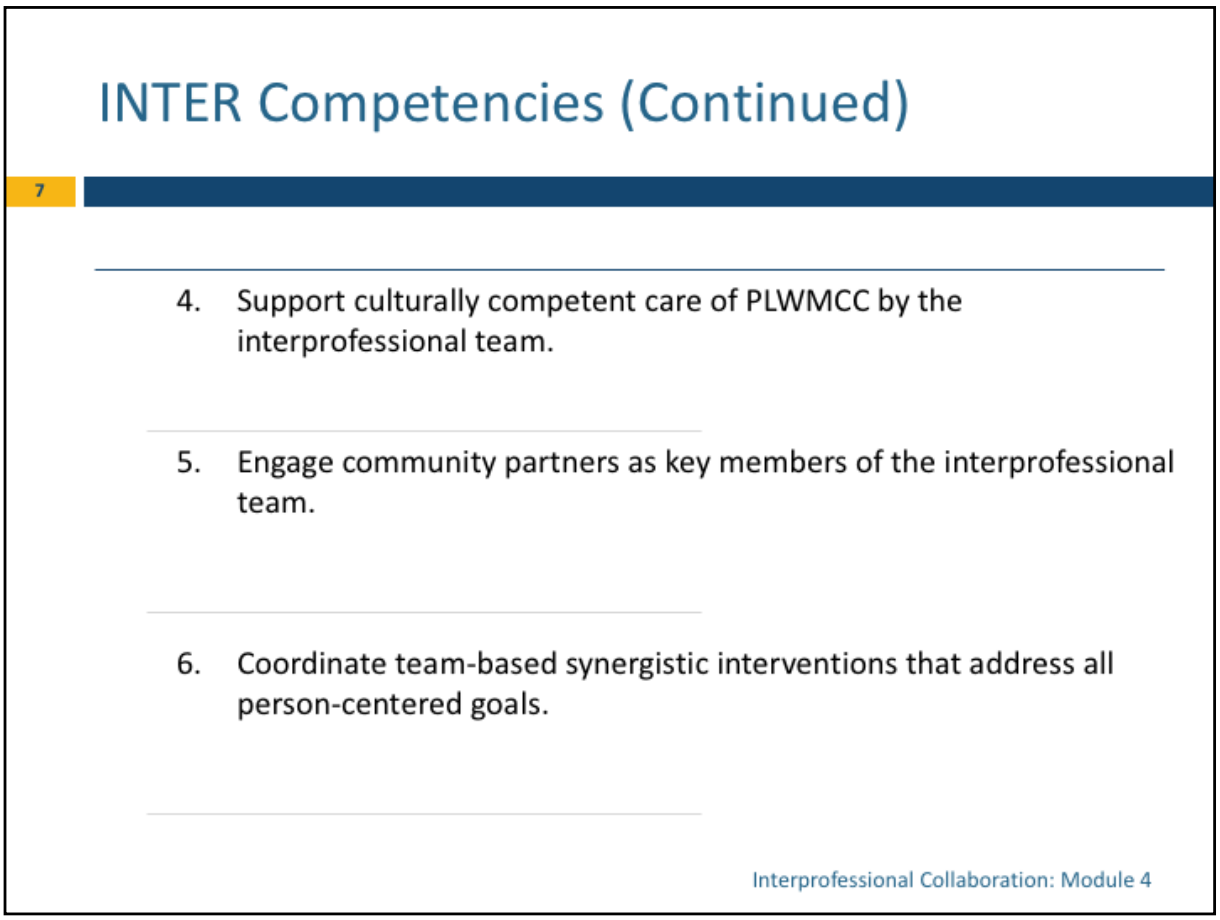
The following six competencies for Interprofessional Collaboration are needed to appropriately provide care for PLWMCC. The underpinning concepts that support these competencies will be discussed in greater detail in this presentation.

The competencies are

INTER 1. Recognize that PLWMCC are central members of their own healthcare teams.

INTER 2. Negotiate roles and responsibilities with all team members that facilitate working within their full scopes of practice.

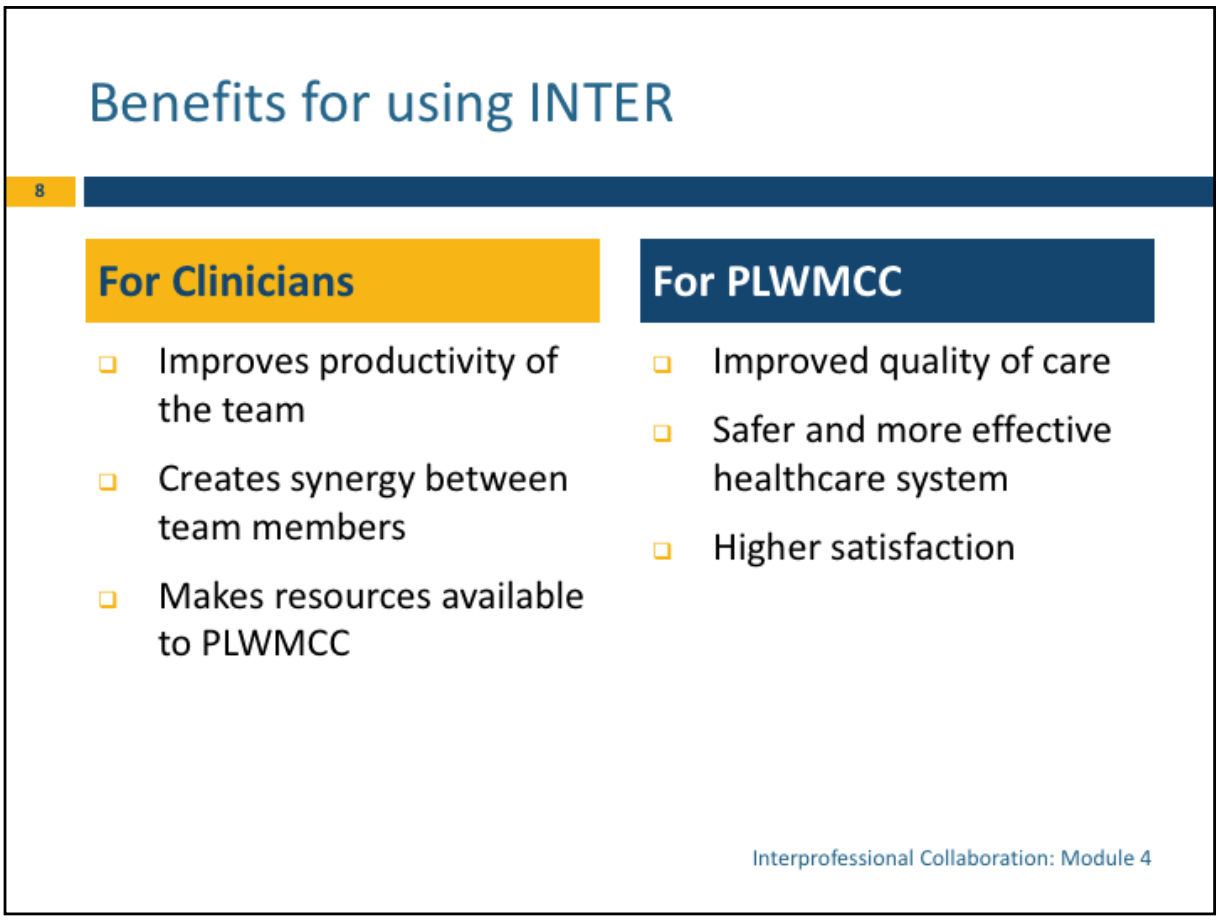
INTER 3. Collaborate with all team members in executing the care plan to meet the complex needs of PLWMCC.



INTER 4. Support culturally competent care of PLWMCC by the interprofessional team.

INTER 5. Engage community partners as key members of the interprofessional team.

INTER 6. Coordinate team-based synergistic interventions that address all person-centered goals.



Growing evidence and emerging healthcare models support the importance of effective interprofessional collaborations. Collaborating through an interprofessional team increases productivity of the team thereby decreasing burden on individual clinicians, creates synergy between team members that leads to higher quality care and makes resources[1] available to the PLWMCC that may not have been otherwise.

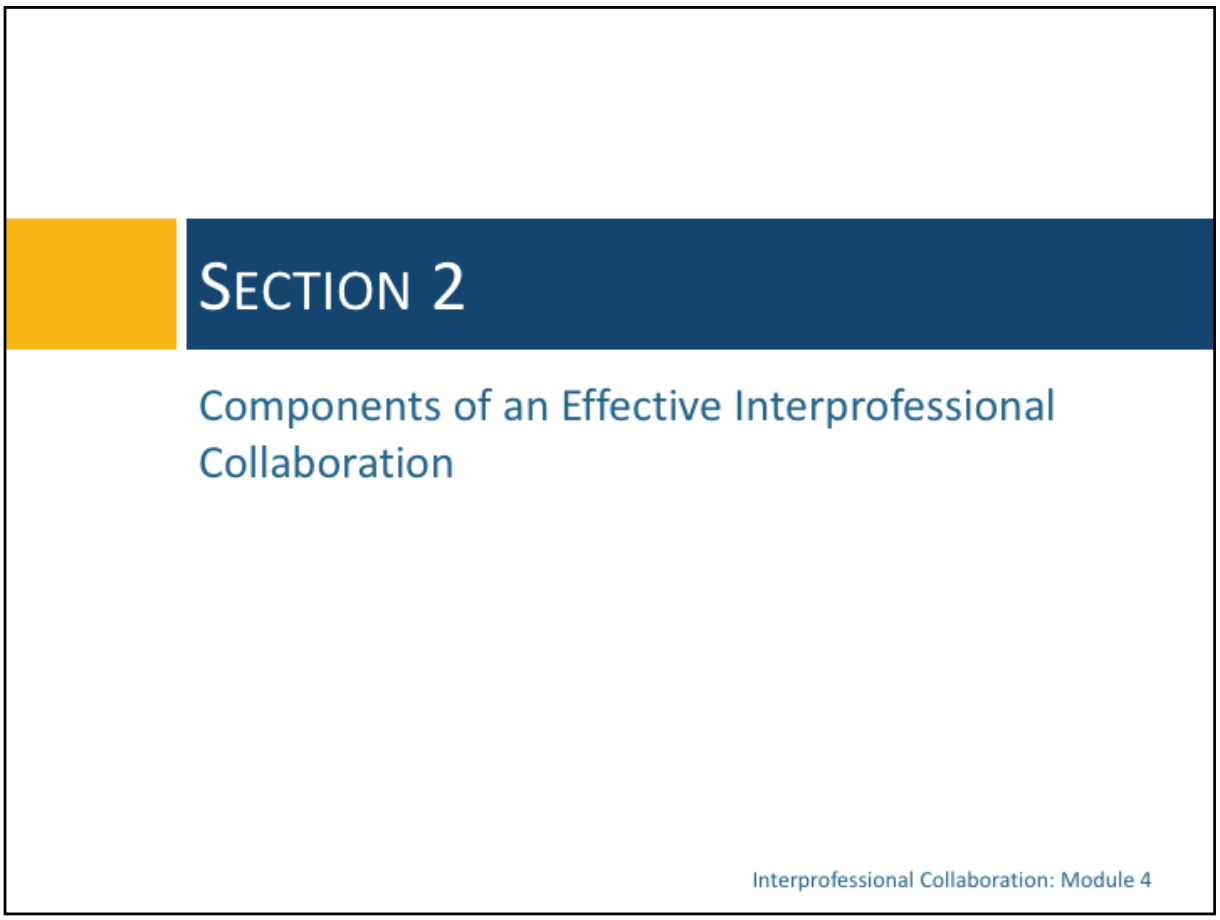
Many aspects of interprofessional collaboration can result in improved care quality, safer and more effective health care system for PLWMCC[2]; and higher PLWMCC satisfaction[3].

References:

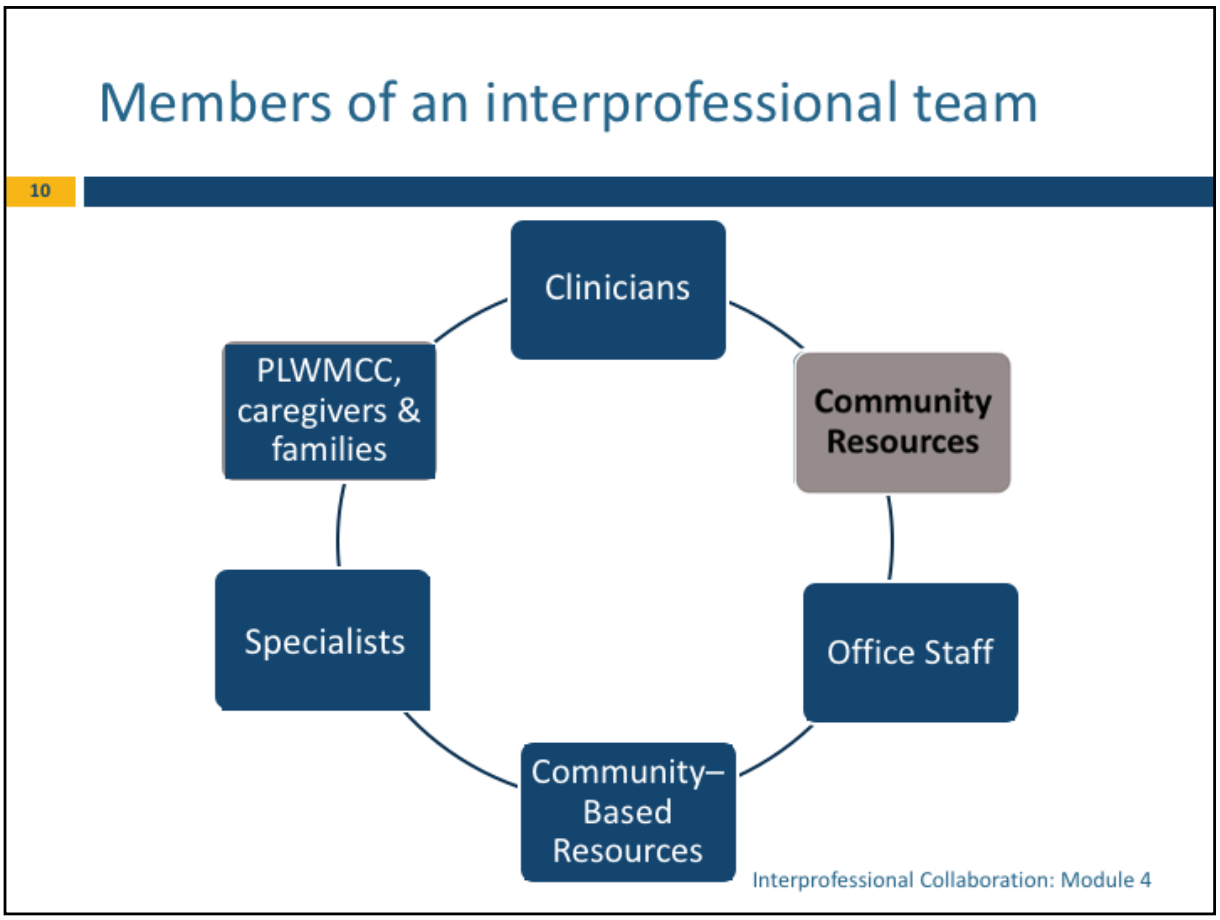
[1]Vanderwielen, L. M., Vanderbilt, A. A., Dumke, E. K., Do, E. K., Isringhausen, K. T., Wright, M. S., Enurah, A. S., Mayer, S. D., & Bradner, M. (2014). Improving public health through student-led interprofessional extracurricular education and collaboration: a conceptual framework. *J Multidiscip Healthc, 7*, 105-110.

[2] Aston, S. J., Rheault, W., Arenson, C., Tappert, S. K., Stoecker, J., Orzoff, J., Galitski, H., & Mackintosh, S. (2012). Interprofessional education: a review and analysis of programs from three academic health centers. Acad Med, 87(7), 949-955.

[3] Schoenbaum, S. C., & Okun, S. (2015). High performance team-based care for persons with chronic conditions. *Isr J Health Policy Res, 4*, 8.



This section – Components of an effective interprofessional collaboration - describes the configuration of teams, key components, models of care that utilize INTER and challenges of INTER.



There are many different configurations of interprofessional teams, depending on the healthcare system, but often the team is comprised of: Clinicians, professional staff and non-professional staff [10] The interprofessional team can also extend to include direct care workers, community health workers and staff in the community that care for PLWMCC as well as PLWMCC and their families and caregivers.

Each member of the team understands their roles and responsibilities which are appropriate to scope of practice and knowledge and engage with other team members regarding questions and concerns that facilitate shared person-centered problem solving [1]. Interprofessional teams include those who work to meet the needs of the individual person with MCC.

For example:

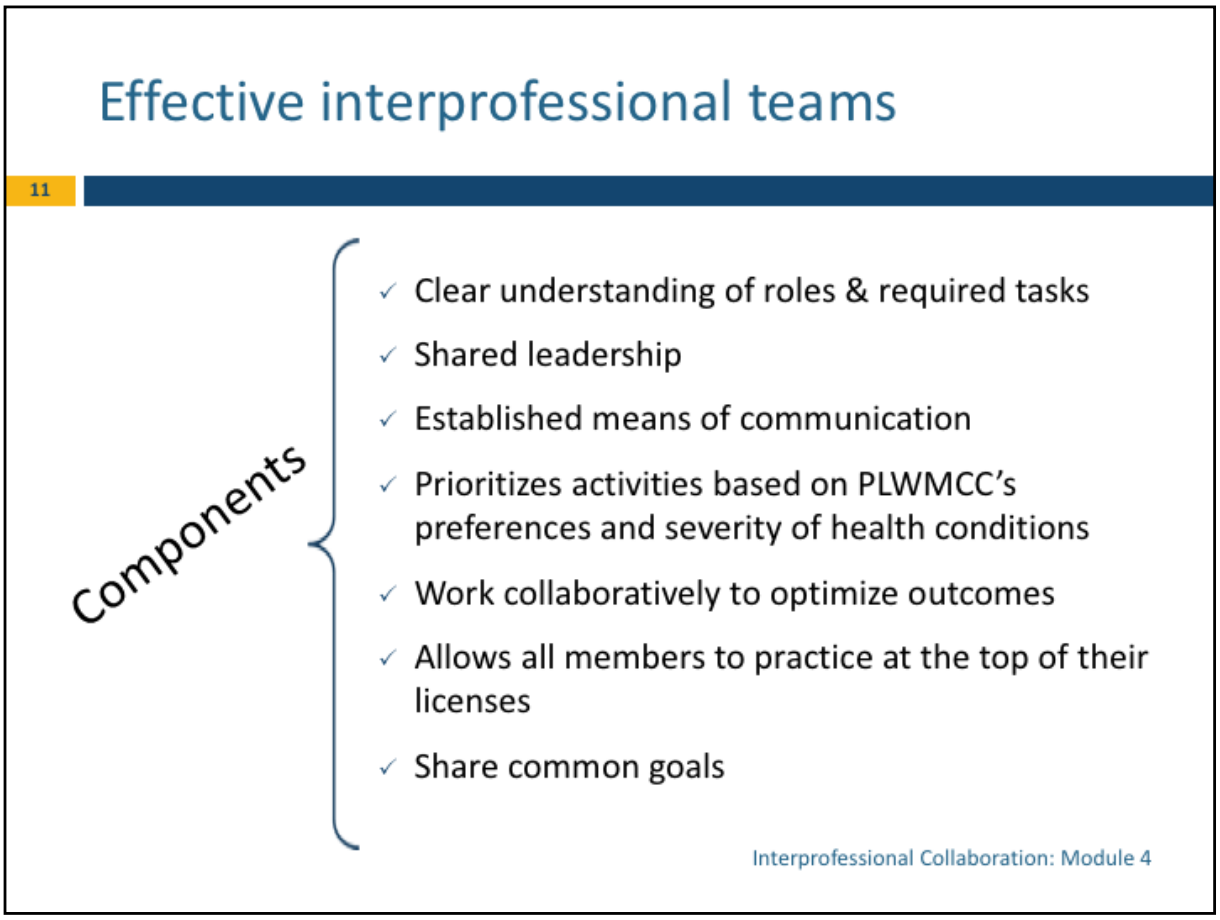
- Clinicians[10] (physicians, nurse practitioners, and physician assistants);
- Professional staff (registered nurses, Licensed practical nurses, pharmacists, dentists, psychiatrists/psychologists, behavioral health providers, social workers, physical & occupational therapists);
- Specialists (cardiologists, pulmonologists, surgeons)
- Other office staff (Medical assistants, front office staff, community health workers and patient navigators);
- Community-based staff (public health workers; program facilitators/coordinators and health coaches)
- PLWMCC, their families and caregivers [14]
- Inclusion of PLWMCC and their families and caregivers is essential as managing their disease and symptoms, along with carrying out activities of daily living, will most often occur outside of a clinical setting.

References:

1. Schmitt, M., Blue, A., Aschenbrener, C. A., & Viggiano, T. R. (2011). Core competencies for interprofessional collaborative practice: reforming health care by transforming health professionals' education. *Acad Med, 86*(11), 1351.

10. Ladden, M. D., Bodenheimer, T., Fishman, N. W., Flinter, M., Hsu, C., Parchman, M., & Wagner, E. H. (2013). The emerging primary care workforce: preliminary observations from the primary care team: learning from effective ambulatory practices project. *Acad Med, 88*(12), 1830-1834.

14. Interprofessional Education Collaborative Expert Panel. Core competencies for interprofessional collaborative practice: Report of an expert panel. . (2011). Washington, D.C.: Interprofessional Education Collaborative.



Members of an interprofessional team organize themselves through common goals, work collaboratively to optimize outcomes[1], and have a clear understanding of their role on the team and the tasks required of them to optimize the health of the PLWMCC. Leadership is distributed throughout the team and changes as tasks change and goals of the care plan are met[2,3]. Teams strive to be actively interdependent and work through established means of communication to ensure various aspects of PLWMCC health care needs are addressed[4].

References:

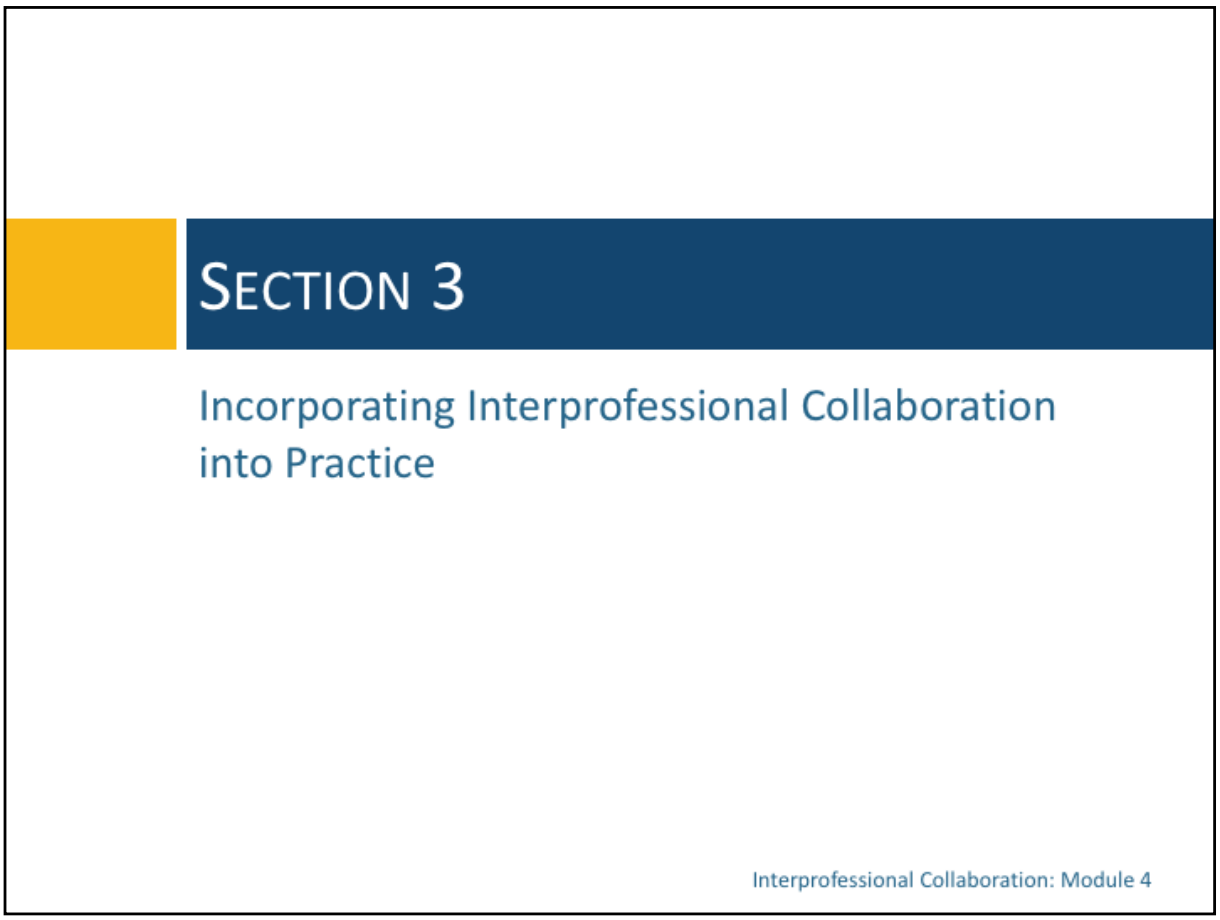
[1] Vanderwielen, L. M., Vanderbilt, A. A., Dumke, E. K., Do, E. K., Isringhausen, K. T.,… & Bradner, M. (2014). Improving public health through student-led interprofessional extracurricular education and collaboration: a conceptual framework. *J Multidiscip Healthc, 7*, 105-110.

[2] Tubbesing, G., & Chen, F. M. (2015). Insights from exemplar practices on achieving organizational structures in primary care. *J Am Board Fam Med, 28*(2), 190-194.

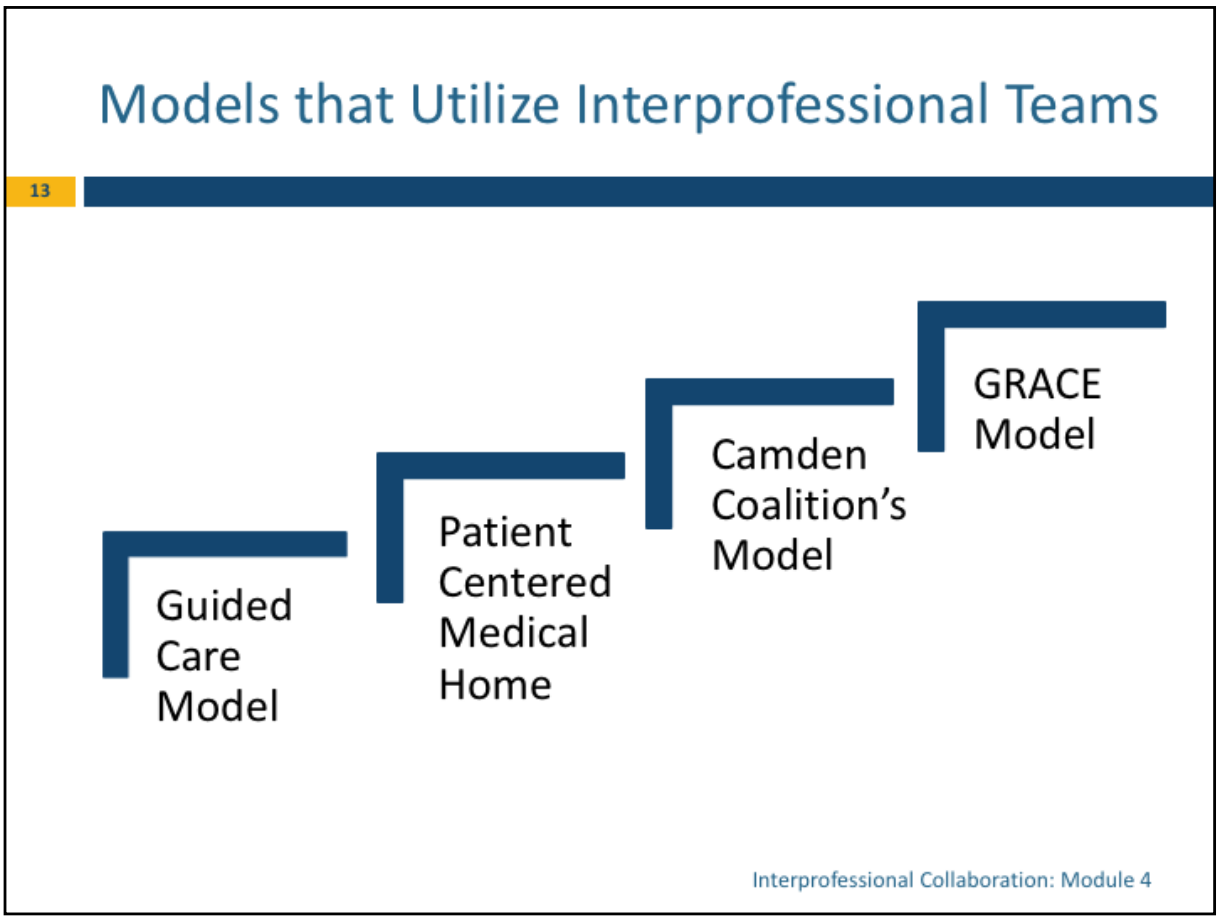
[3] Agency for Healthcare Research and Quality Clinical-Community Linkages. Retrieved from http://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/.

[4] Boyd, C. M., & Lucas, G. M. (2014). Patient-centered care for people living with multimorbidity. *Curr Opin HIV*

AIDS, 9(4), 419-427.



This section “incorporating INTER into practice” provides effective mechanism for healthcare professionals to help people manage their multiple chronic conditions.



Healthcare providers and systems are developing team-based models of care that encourage working relationships between clinical and community-based providers, PLWMCC, their caregivers and families to achieve the Institute for Healthcare Improvement's Triple Aim of high quality care, improved health at optimal costs[1]. Several models have improved PLWMCC's quality of care and quality of life. Here are three examples of models of care that utilize interprofessional teams:

1. The Guided Care Model uses nurse-led teams to meet the complex care needs of PLWMCC. Other programs are experimenting with other team configurations to improve care for PLWMCC.
2. Patient Centered Medical Home (PCMH) models support interprofessional team care that optimizes roles of each team member including the primary care provider (i.e., physicians, nurse practitioners, physician assistants), nurses, medical assistants, pharmacists, social workers, psychologists, dieticians, and specialists.
3. The Camden Coalition of Healthcare Providers has developed an innovative care management model for high needs / high costs patients in Camden NJ. The Care Management Team relies on home visits with patients to coordinate doctors' appointments, transportation, and social services. The Team provides holistic medical care as well as root cause analysis and solutions to the often intertwined issue of poverty and disease that plague its patients[2].
4. The Geriatric Resources for Assessment and Care of Elders (GRAMCE) model utilizes nurse practitioners and social workers to meet with patients in their home and then consults with an interprofessional team to develop an individualized care plan.

References:

[1]Institute for Healthcare Improvement Triple Aim Initiative. Retrieved from http://www.ihi.org/Engage/Initiatives/TripleAim/pages/default.aspx.

[2] Abraczinskas, J., Brenner, J. (2012). Camden Coalition's Model for High Needs Patients. *Physicians News Digest.*

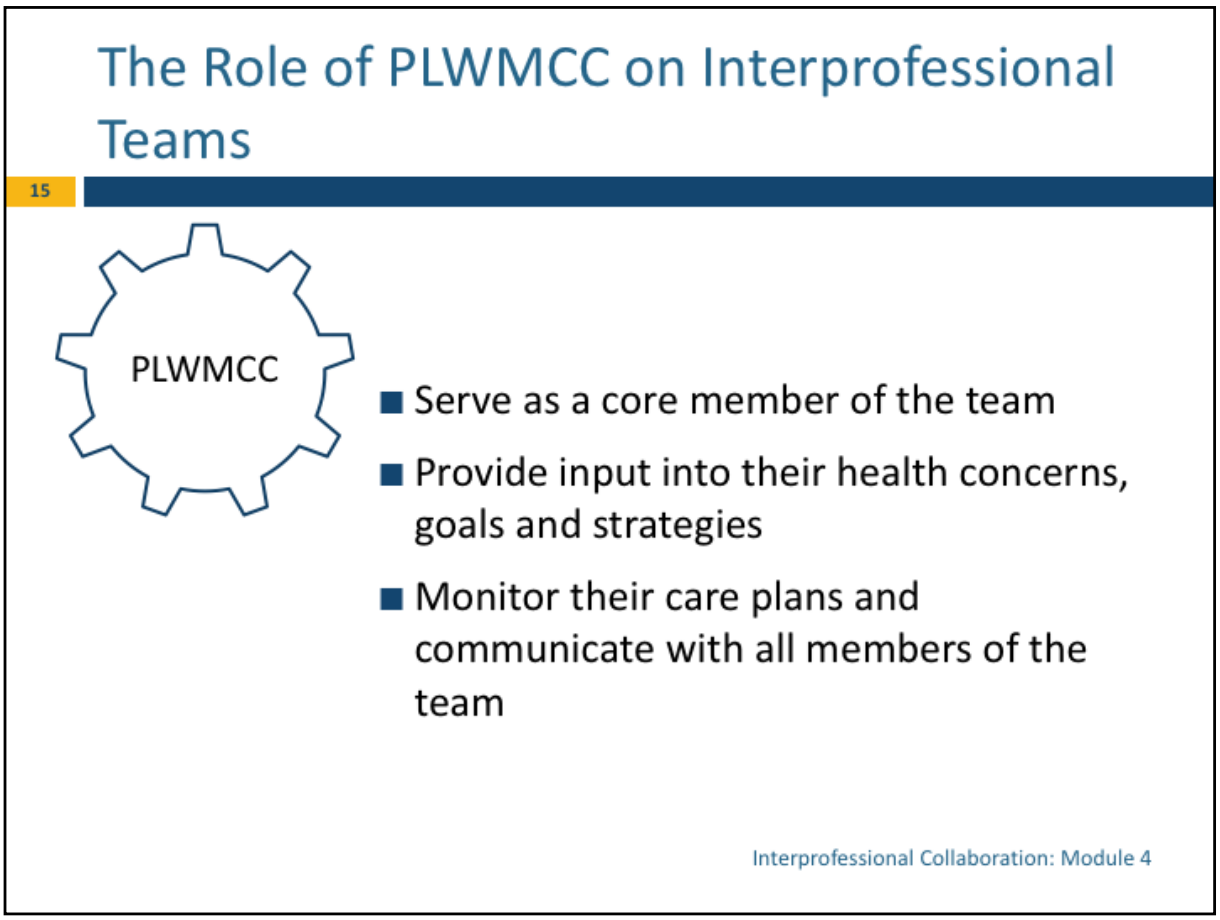
Opportunities to Integrate INTER into Practice

14

Interprofessional Collaboration: Module 4

The following strategies are further described in the next two slides -

- PLWMCC and Interprofessional Teams
- Clinical Community Linkages
- Care Plans

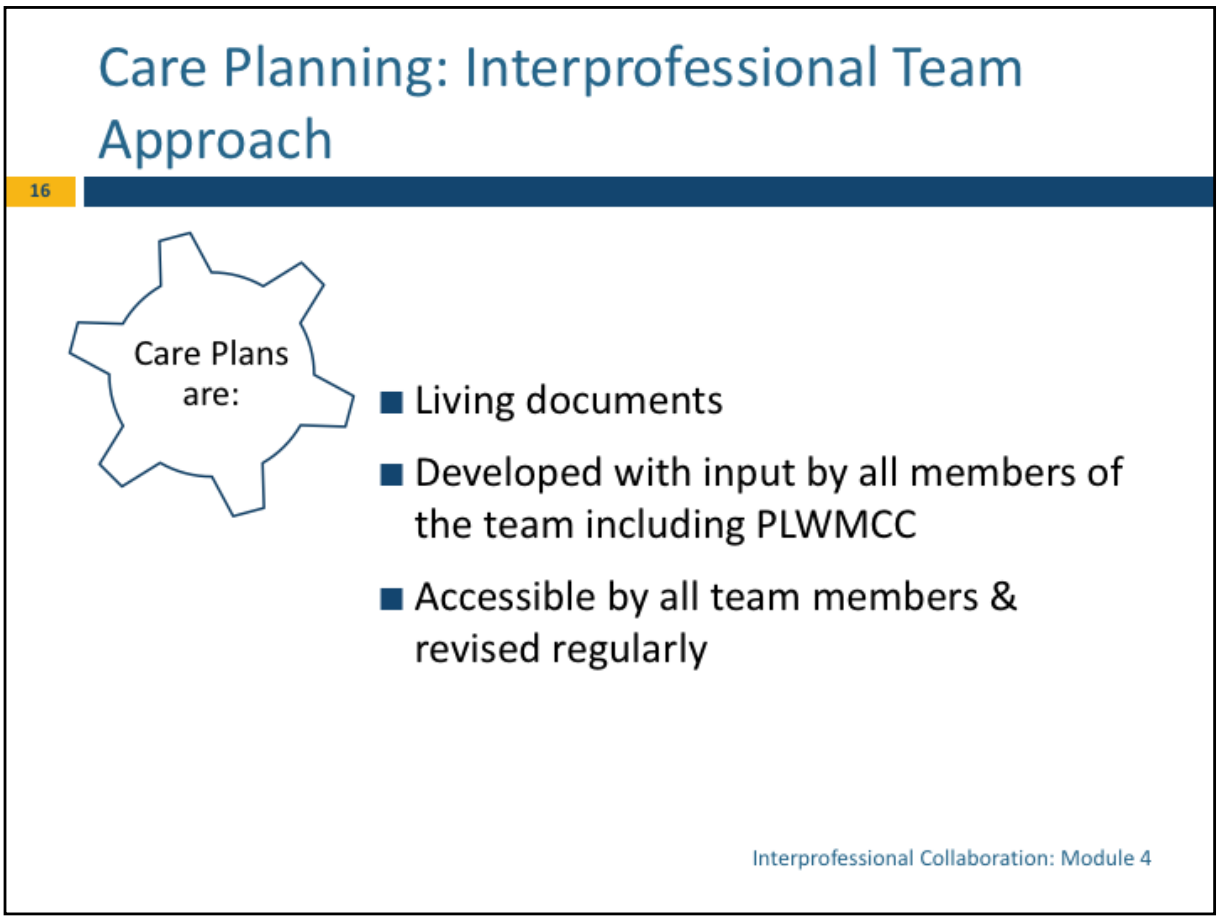


PLWMCC are integral to the Interprofessional Team as they know best their own chronic conditions in the context of their lives.
Interprofessional teams strive to provide culturally and linguistically appropriate care by integrating team members who can help achieve this goal.

PLWMCC are core members of interprofessional teams.

PLWMCC and their families and caregivers are included in discussions about their health concerns and goals, and developing strategies for addressing those concerns and meeting goals.

PLWMCC help develop and monitor their care plans and communicate with members of the interprofessional team when needed.



Care plans place the concerns of PLWMCC at the forefront of the plan.
The care plan should include a clear communication strategy to ensure all team members are aware of goals that have been met or modified.

Care plans are:

-Living documents that elaborate on goals, strategies, and processes for optimizing the care and health of PLWMCC;

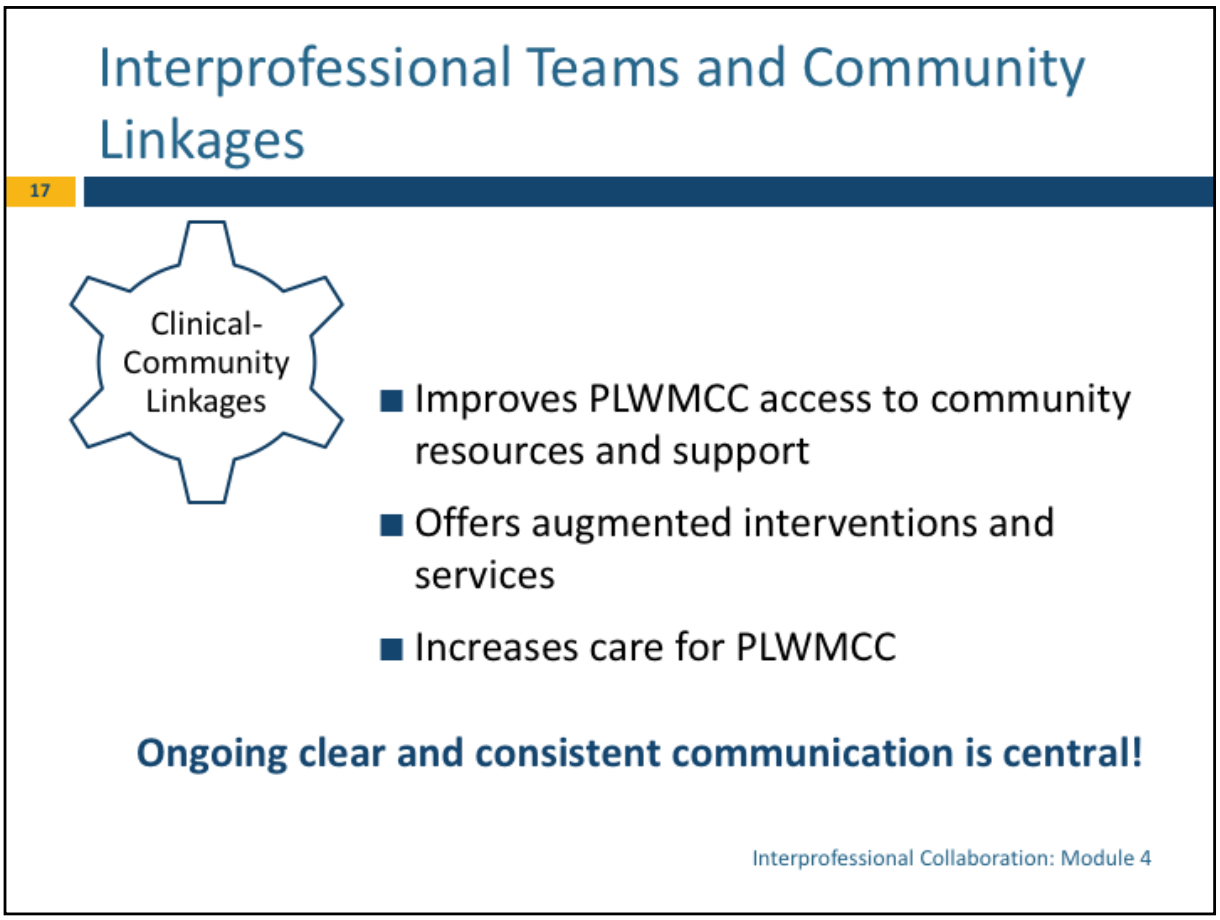
- Developed by and agreed upon by all members of the team including PLWMCC;

- Accessible by all team members and reviewed and revised regularly as goals are changed and met[1].

For PLWMCC who are children or have cognitive impairments (i.e., dementia or Alzheimer's), their designated family member or POA (Power of Attorney) should be highly involved in their care plan. Not all PLWMCC in this group will have the ability to review, understand, provide input and agree to a care plan because of their conditions affecting their cognitive abilities.

References:

[1] Harris, M. F., Dennis, S., & Pillay, M. (2013). Multimorbidity: negotiating priorities and making progress. *Aust Fam Physician, 42*(12), 850-854.



Effective relationships between clinical and community partners can provide a win-win situation for PLWMCC, clinicians and community partners.

Community Partnerships require time and effort to create and maintain. It is the responsibility of one or more members of the interprofessional care team to identify appropriate resources and connect the PLWMCC to those resources as needed. One of the most critical responsibilities is to ensure communication between the clinical and community organizations is clear and consistent [24].

Creating sustainable, effective linkages between the clinical and community settings can:

Improve PLWMCC access to community resources and support to prevent, delay, or manage their chronic diseases;

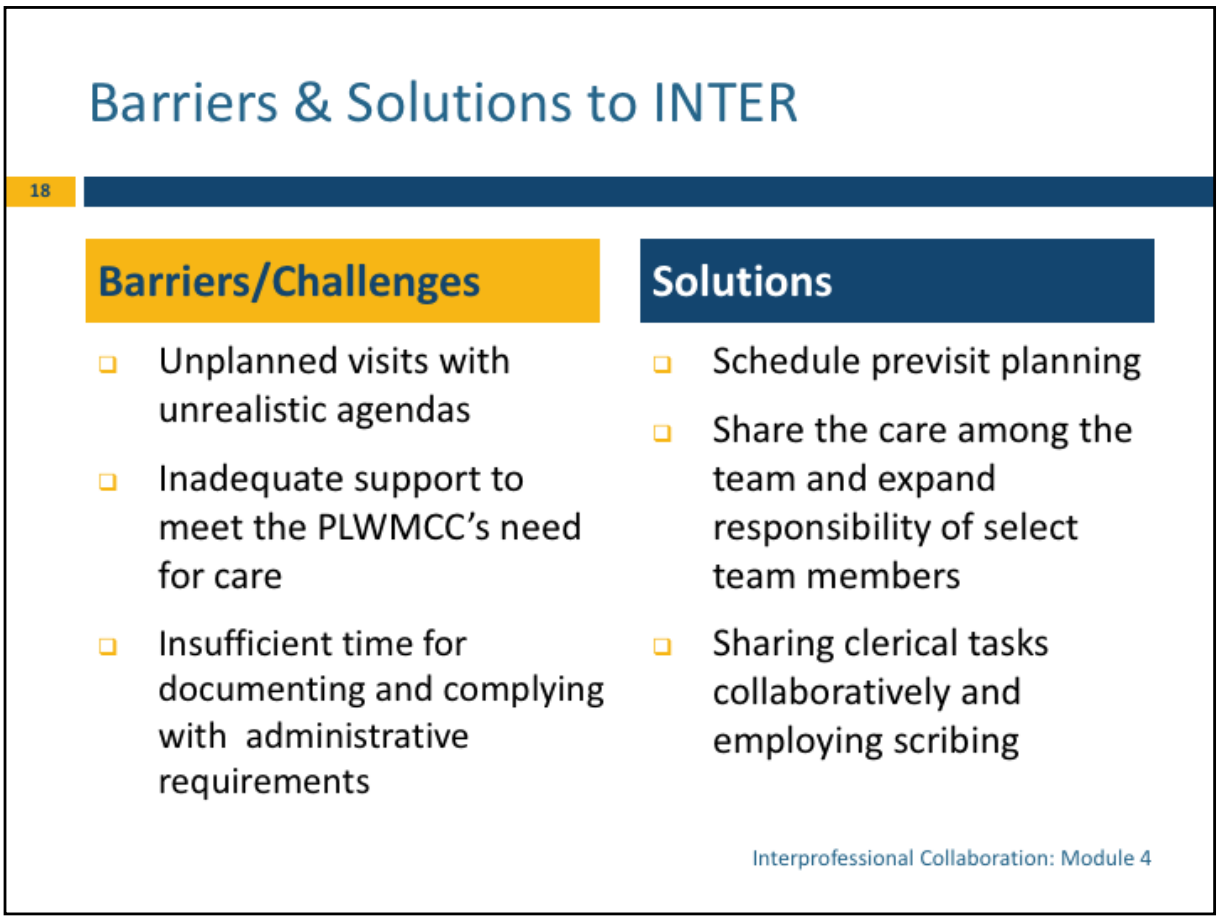
- Offer augmented interventions and services that the clinical health care setting may not have the time, resources, or expertise to provide;
- Increase care for PLWMCC, who use community resources [31].

References:

24. Agency for Healthcare Research and Quality Clinical-Community Linkages. Retrieved from

http://www.ahrq.gov/professionals/prevention-chronic-care/improve/community/.

31. Woolf, S. H., Dekker, M. M., Byrne, F. R., & Miller, W. D. (2011). Citizen-centered health promotion: building collaborations to facilitate healthy living. *Am J Prev Med, 40*(1 Suppl 1), S38-47.



Growing evidence and emerging healthcare models support the importance of effective interprofessional collaborations. Collaborating through an interprofessional team increases productivity of the team thereby decreasing burden on individual clinicians, creates synergy between team members that leads to higher quality care and makes resources[1] available to the PLWMCC that may not have been otherwise.

Many aspects of interprofessional collaboration can result in improved care quality, safer and more effective health care system for PLWMCC[2]; and higher PLWMCC satisfaction[3].

Here are some barriers that interprofessional teams face which cause them to be suboptimal along with potential solutions.

- Barrier: Unplanned visits with unrealistic agendas; Solution: regularly scheduled visits with time specific agendas
- Barrier: Inadequate support to meet the PLWMCC's need for care; Solution: to share the care among the team and/or expand responsibilities of team members and to ensure that all team members are working within their full scopes of practice.
- Barrier: Insufficient time for documenting and complying with administrative requirements; Solution: sharing clerical tasks collaboratively or employing scribing.

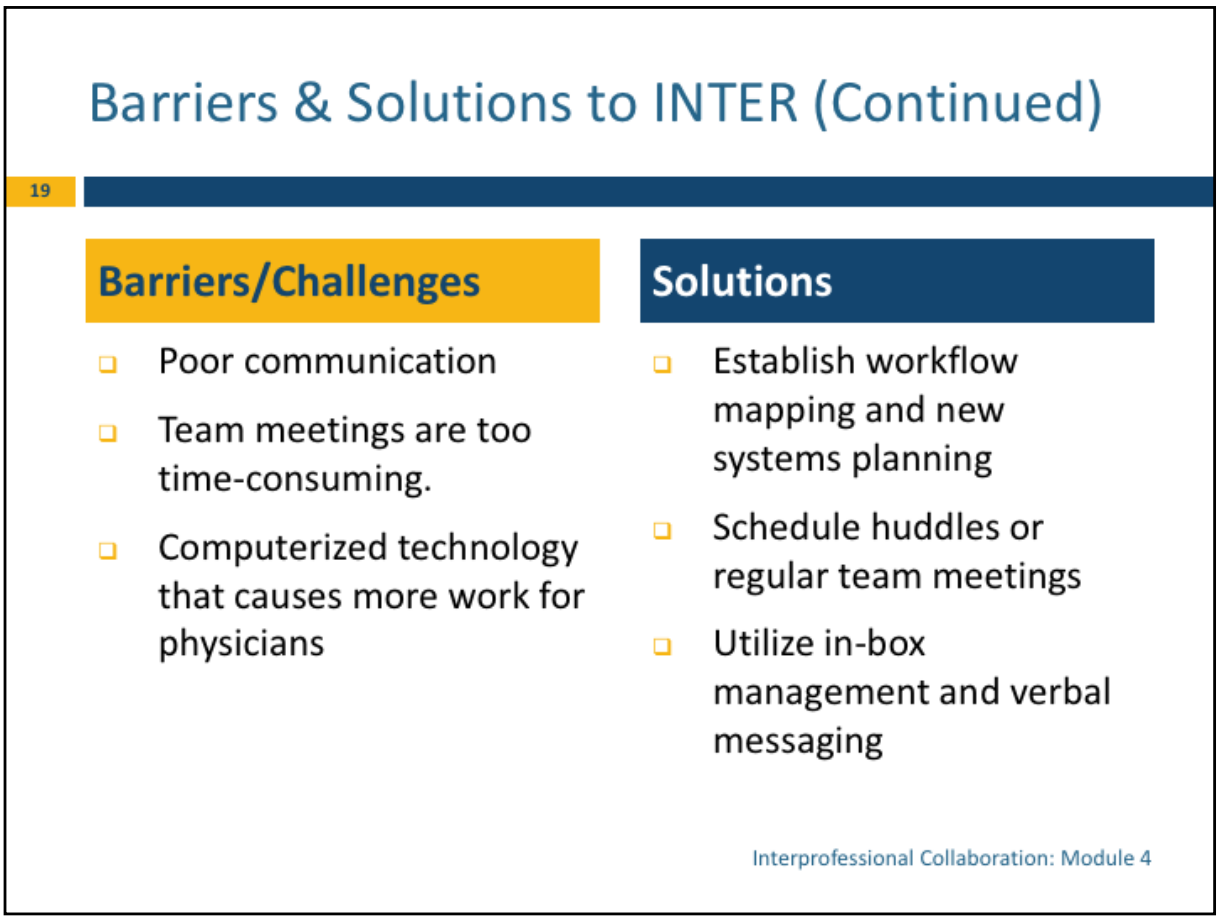
References:

[1]Vanderwielen, L. M., Vanderbilt, A. A., Dumke, E. K., Do, E. K., Isringhausen, K. T., Wright, M. S., Enurah, A. S., Mayer, S. D., & Bradner, M. (2014). Improving public health through student-led interprofessional extracurricular education

and collaboration: a conceptual framework. *J Multidiscip Healthc, 7*, 105-110.

[2] Aston, S. J., Rheault, W., Arenson, C., Tappert, S. K., Stoecker, J., Orzoff, J., Galitski, H., & Mackintosh, S. (2012). Interprofessional education: a review and analysis of programs from three academic health centers. Acad Med, 87(7), 949-955.

[3] Schoenbaum, S. C., & Okun, S. (2015). High performance team-based care for persons with chronic conditions. *Isr J Health Policy Res, 4*, 8.



Poor communication is the main cause of poor outcomes and errors in healthcare and can cause fragmented care. Effective communication may reduce healthcare errors and improve satisfaction of care teams.[1] Practicing and improving communication techniques are required all of the time from all team members. Utilizing standardized documentation practices along with verbal messaging and in-box management[2] are ways to ensure that quality and continuity of care are achieved for PLWMCC.

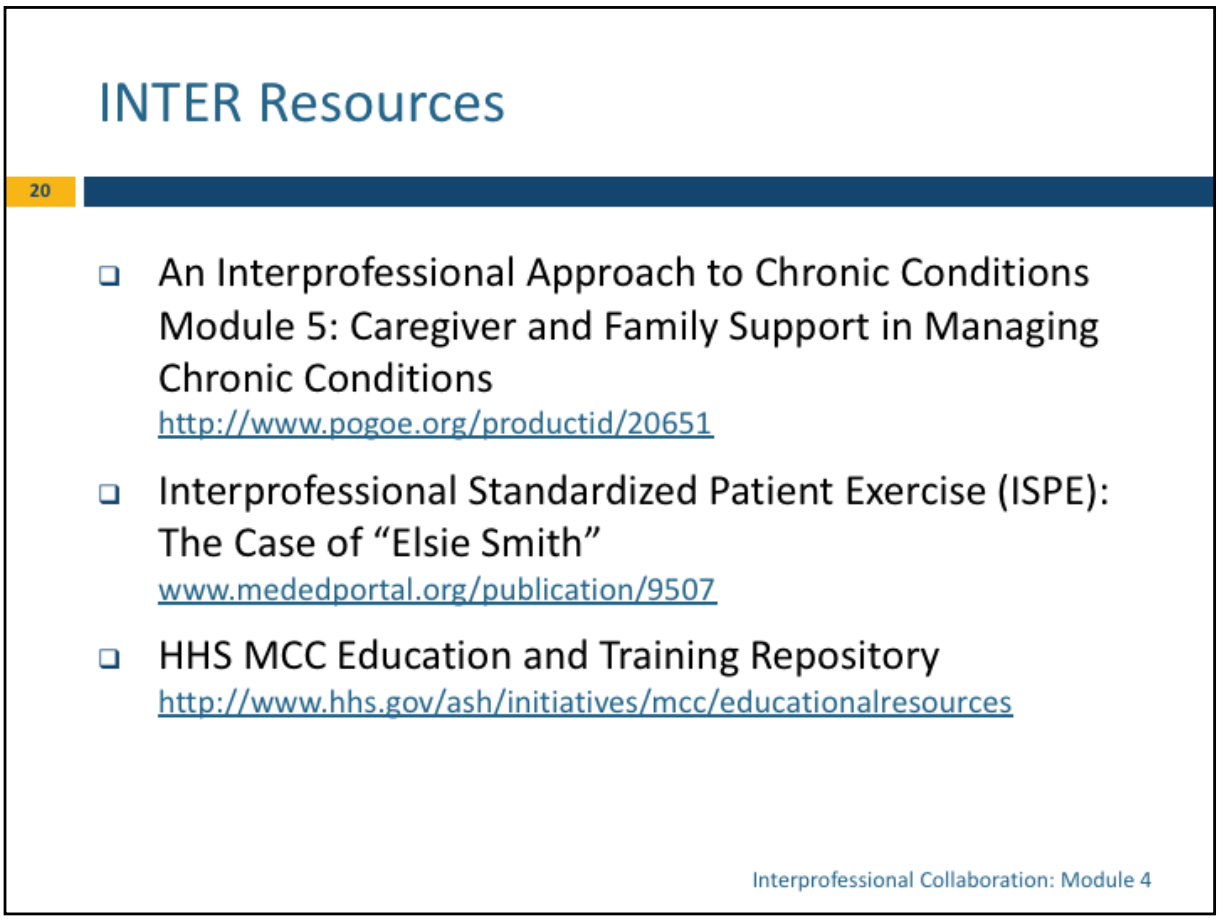
Time constraints may be a challenge that prevents interprofessional teams from meeting whether there are conflicting schedules or not enough time for everyone to meet all together. Establishing work flow mapping and new systems planning[2] coupled with conducting time efficient meetings can improve workflow for all. Scheduling huddles or regular team meetings in an specific timeframe allow the meetings to be more efficient and effective.

Some EHR barriers include differing electronic communications tools and documentation errors due to the differing electronic communications tools. When at all possible, using shared electronic records or other electronic communication methods may reduce burden for the interprofessional team.

References:

1 Scotten, M., Manos, EL, Malicoat, A., & Paolo, A.M. (2015). Minding the gap: Interprofessional communication during inpatient and post discharge chasm care. *Patient Ed and Counseling, 98*, 895-900.

2 Sinsky, CA, Willard-Grace, R, Schutzbank, AM, Skinsky, T.A., Margolius, D, & Bodenheimer, T. (2013). In search of joy in practice: A report of 23 high-functioning primary care practices. Ann Fam Med, 11(3) 272-278.



The following resources may further support interprofessional collaborations.

- An Interprofessional Approach to Chronic Conditions 5: Caregiver and Family Support in Managing Chronic Conditions is a 30-minute module that gives healthcare professionals and students an understanding of the caregiver role using an interprofessional approach to care.
- The Interprofessional Standardized Patient Exercise (ISPE) provides students with a structured learning experience working within an interprofessional health care team. The case of "Elsie Smith" involves multiple complex chronic medical conditions in an older adult with many needs and limited resources. It highlights the need to address medical, functional status, and social domains, among others, and accordingly is designed to be relevant to many health professions.

- **To find more MCC related education and training resources for health professionals, visit the HHS MCC Education and Training Repository at http://www.hhs.gov/ash/initiatives/mcc/educationalresources.**

References:

[1] Borden C., & Waddell-Terry, T. MS (2010). An Interprofessional Approach to Chronic Conditions 5: Caregiver and Family Support in Managing Chronic Conditions. Retrieved on June 12, 2014 from http://www.pogoe.org/productid/20651