

Interprofessional Education in the US: What We Can Learn from Our Successes and Failures

Phillip G. Clark, ScD
University of Rhode Island

Presentation at the Annual Meeting of the
Canadian Society of Respiratory Therapists
St. John's, Newfoundland, 13 May, 2010



Outline of Presentation

■ Examine

- ◆ Context for interprofessional education (IPE) and practice (IPP) in the US

■ Review

- ◆ Selected historical programs

■ Summarize

- ◆ Lessons from history for the present

■ Develop

- ◆ Some recommendations and guidelines for designing IPE programs
- ◆ Some reflections specifically on respiratory therapy and teamwork

Some Good News

- Recent Institute of Medicine (IoM) reports in the US supporting interprofessional education (IPE) and practice (IPP) in health
 - ◆ *Health Professions Education: A Bridge to Quality* (2003)
 - ◆ *Retooling for an Aging America: Building the Health Care Workforce* (2008)
- Primary focus is on quality improvement to avoid medical errors and mistakes

Some Bad News

- Since the 1940s, the US has had a roller-coaster history of developing IPE and IPP
- “As with the mythical Sisyphus, each forward push seems to end with a return to the point of origin, with little tangible evidence of impact or permanence. . . [E]ach new generation seems to have to repeat the experiences and frustrations of the past” (Baldwin, 1996, p. 182).

Understanding Differences in the US Background

■ Different histories

- ◆ “Life, liberty, and the pursuit of happiness”
 - ◆ US Declaration of Independence (1776)
- ◆ “Peace, order, and good government”
 - ◆ Canadian Constitution Act (1867)

■ Different social values

- ◆ Independence and personal autonomy
- ◆ Collectivism and community

Understanding the US Background

(cont'd.)

■ Emphasis on

- ◆ Developing models, not on fundamentally changing the context
- ◆ US as the “land of the demonstration project”

Implications for Health Care

■ Health care systems

- ◆ Universal health care (Canada)
- ◆ Fragmented care (US)
- ◆ Change is more deliberate (Romanow report in Canada) vs. more incremental (divisive debate in US)

■ Health professions education

- ◆ Lack of support external to educational settings for IPE
- ◆ Lack of clear link between IPE and IPP

Some Major Models from the Past and the Present

- Veterans Administration Medical Centers
 - ◆ Interdisciplinary Team Training Programs (ITTP)
- Geriatric Education Centers
 - ◆ US Bureau of Health Professions
- Rural Interdisciplinary Training Programs
 - ◆ US Bureau of Health Professions
- Hartford Foundation (New York)
 - ◆ Geriatric Interdisciplinary Team Training (GITT) Program

Veterans Administration (VA) ITTP

- Embedded in clinical education settings at 12 VA Medical Centers across the US
- Trained a whole generation of clinicians and leaders in IPE and IPP
- One of longest-lived programs, eventually falling victim to VA budget cuts in the late 1990s
- Recent major initiative in developing primary care teams within the VA

Geriatric Education Centers

- Program in existence since 1983
- Currently, 48 GECs nationally
- Required to offer interdisciplinary education and training in geriatrics
 - ◆ Academic programs
 - ◆ Continuing education
- Substantial variability
- Little in-depth interprofessional teamwork training
- Increasing emphasis on evaluation of program impacts on clinician behavior and patient outcomes

Rural Interdisciplinary Training

- Program started in 1990 (no longer funded)
- Focus on unique context of rural environment for IPE
 - ◆ Broader definition of health
 - ◆ More psychosocial and health promotion based
 - ◆ Need for community focus on problems
 - ◆ Blurring of traditional roles and responsibilities among professions
 - ◆ Wider array of team members
 - ◆ Paraprofessionals from community

Hartford GITT

- Demonstration projects in 8 academic health science centers, linked to provider settings
- Successful in
 - ◆ Developing curricula and materials to be implemented in other settings (“GITT Kit”)
- Modestly successful in
 - ◆ Making measurable impacts on trainee attitudes and skills in IPP
- Not so successful in
 - ◆ Long-term maintenance or program sustainability

Discussion of Implications

- Sometimes we can learn as much, or more, from failures as from successes
- If you've seen one interprofessional program, you've seen one interprofessional program
- Context matters!
 - ◆ Acute care
 - ◆ Long term care
 - ◆ Community care
 - ◆ Health promotion
 - ◆ Urban
 - ◆ Rural

Discussion of Implications (cont'd.)

- Some based on specific evaluations
 - ◆ Hartford GITT
 - ◆ Leipzig et al. (2002)
 - ◆ Reuben et al. (2004)
- Others on general patterns and observations
 - ◆ Qualls & Czirr (1988)
 - ◆ Baldwin (1996)
 - ◆ Satin (1987)
 - ◆ Clark (2004)

Hartford GITT Findings

(Leipzig et al., 2002)

- Attitudes toward working on IP teams
 - ◆ Medical residents and advanced practice nursing and MSW students all support IPP as benefiting geriatric patients
 - ◆ Significant differences between MDs and NPs/MSWs with regard to leadership, authority, and responsibility on teams
 - ◆ Is earlier teamwork intervention needed for MDs before attitudes are set?

Hartford GITT Findings (cont'd.)

(Reuben et al., 2004)

■ Concept of “disciplinary split”

- ◆ Attitudinal and cultural traditions of the different health professions faculty and students are important obstacles to creating an optimal interdisciplinary team training experience
- ◆ In most cases, these obstacles impede planned operation or effectiveness of a program

Hartford GITT Findings (cont'd.)

(Reuben et al., 2004)

- Attitudes and experience
 - ◆ Differing histories of collaboration/independence
- Regulatory requirements
 - ◆ Limitations on preceptor qualifications/experiences for certification
- Faculty support
 - ◆ Generally, low level of medical support
- Participation of trainees
 - ◆ Variability in duration and dose of training

Hartford GITT Findings (cont'd.)

(Reuben et al., 2004)

- Level of training
 - ◆ More vs. less
- Trainee expectations
 - ◆ Based on model of care in the profession
- Hierarchy within system
 - ◆ Hierarchy/egalitarian tension
- Faculty and trainee roles in clinical experiences
 - ◆ Hospital settings reinforce hierarchy
 - ◆ Home care settings attenuate it

Models of Professional and Team Functioning (Qualls & Czirr, 1988)

■ Models of professional functioning

- ◆ Logic of assessment
 - ◆ “Ruling in” vs. “ruling out”
- ◆ Focus of professional efforts
 - ◆ Acute/medical vs. social/functional
- ◆ Locus of responsibility
- ◆ Pace of action

■ Models of teamwork

- ◆ Focus of group’s attention
 - ◆ Outcome vs. process
- ◆ Expectations about decision-making
- ◆ Beliefs about interdisciplinary practice

Some Lessons Learned (Baldwin, 1996)

■ Understanding and achievement

- ◆ Interdisciplinary concepts are not easy to understand and even more difficult to achieve in practice

■ Challenges to sustainability

- ◆ Few programs are able to sustain their efforts in the absence of prolonged sponsorship and funding

■ Measurement

- ◆ This same problem has hampered efforts to measure the true educational and clinical potential of IPE and IPP

More Lessons Learned (Satin, 1987)

■ High priority

- ◆ IPE itself must be the highest priorities of the program
- ◆ Participants must be conscious and supportive of this

■ Power

- ◆ The power controlling the educational program must understand and be committed to IPE

■ Location

- ◆ Successful IPE may have to be located outside of traditional academic structures

More Lessons Learned (cont'd.)

■ Virtues

- ◆ There must be honesty, trust, and respect among key participants

■ Resources

- ◆ Resources must be provided to support the goals and objectives of IPE

Final Lessons Learned (Baldwin, 1996)

- “The issue is not ‘team vs. no team,’ but rather what kind of team, for what purpose, and under what conditions.
- “Interdisciplinary health care teams are not an end in themselves, but a means for more effective communication and cooperation among health professionals in the service of patient needs.”

Two Laws of IPE Program

Development (Clark, 2004)

- Law of Academic Inertia
- Law of Permanency of Academic Change

Law of Academic Inertia

- “Academic curricula and the departments in which they reside will resist change unless they experience an external force, such as grant funding or accreditation requirements.”

Corollaries of First Law

■ Situation in higher education

- ◆ Disciplines are built on unique ways of understanding knowledge and professional socialization into characteristic sets of values and behaviors
- ◆ Faculty and administrators have been trained within traditional structures and systems that resist interprofessional innovation

Corollaries of First Law (cont'd.)

■ Consequences

- ◆ Higher ed programs tend to be buffered from external economic, social, and political contexts
- ◆ Academic programs generally are conservative and slow to change in response to external forces
- ◆ Educational programs focus on supplying graduates for jobs that exist now, not necessarily those that will develop in the future

Law of Permanency of Academic Change

- “The degree of permanency of interprofessional change in academic programs is directly proportional to the size of the pressure acting upon them and inversely proportional to the structural and financial resistance to change within the institution.”

Corollaries of the Second Law

- External pressures, such as from the health care system and jobs available within it, may cause long-term change within the “upstream” academic programs preparing professionals for work within that system
- When faced with such internal stressors as reduced resources, academic systems tend to revert to their old ways of operating

Overall Observations and Recommendations

■ Some general observations

- ◆ Academic and health care systems are only indirectly connected and interrelated in the area of workforce development
- ◆ Academic institutions may change in the short term, but long-term change requires consistent and persistent pressures, incentives, and supports

Overall Observations and Recommendations (cont'd.)

- Recommendations within academia
 - ◆ Solutions need to be found in systemic and systematic change, rather than in ad hoc programs and personalities
 - ◆ We need to work top-down and bottom-up, inside and outside the academic setting to bring about meaningful, long-lasting change

Overall Observations and Recommendations (cont'd.)

■ Recommendations within academia (cont'd.)

- ◆ We must work further up the academic stream in terms of creating interprofessional graduate programs to educate new generations of faculty and administrators
- ◆ Theory-based research on IPE and IPP needs to be funded to support the development of scholarship in this area

Overall Observations and Recommendations (cont'd.)

- Recommendations within health care system
 - ◆ We must create a health care system that supports and rewards the interprofessional delivery of health care services
 - ◆ This means changing the financial incentive/disincentive structure for teamwork and educating administrators on its importance

Some Reflections on Respiratory Therapy and Teamwork

(Massachusetts General Hospital, Boston)

■ Entry

- ◆ Recognizes the need for a team approach to patient care
- ◆ Begins developing relationships with the health care team
- ◆ Benefits more from than contributes to team work

Some Reflections on Respiratory Therapy and Teamwork (cont'd.)

■ Clinician

- ◆ Collaborates with members of the patient care team to develop an integrated care plan
- ◆ Identifies the need for improvement in the respiratory care department
- ◆ Begins to see positive effect of own contribution to team work

Some Reflections on Respiratory Therapy and Teamwork (cont'd.)

■ Advanced clinician

- ◆ Actively seeks other health care team members to provide an integrated care plan
- ◆ Develops solutions for implementing improvements in practice
- ◆ Mobilizes team work
- ◆ Contributes to more than benefits from team work

Some Reflections on Respiratory Therapy and Teamwork (cont'd.)

■ Clinical scholar

- ◆ Leads and coordinates operation improvement activities for clinical practice and system improvements
- ◆ Consultation is sought by peers and other members of the health care team
- ◆ Projects a professional image and positively influences practice for better patient care
- ◆ Often leads teams

Some Final Observations

- “Interdisciplinary education is a field littered with the bodies of good intentions.” (Clark, 2004)
- “Despite its logical advantages and productivity, interdisciplinary education is a hard road to travel, with few guides and only sketchy maps. It requires flexibility, creativity, persistence, and, above all, commitment to find ways of continuing to exist. It can be done.” (Satin, 1987)

Final Questions to Consider

- “How can we more effectively link academic IPE with health care system IPP in a way that mutually sustains them?”
- “What are the reciprocal ‘levers of change’ that can be employed to create synergistic and positive changes in both IPE and IPP?”

References

- Baldwin, D. C. (1996). Some historical notes on interdisciplinary and interprofessional education and practice in health care in the USA. *Journal of Interprofessional Care, 10*, 173-187.
- Clark, P. G. (2004). Institutionalizing interdisciplinary health professions programs in higher education: The implications of one story and two laws. *Journal of Interprofessional Care, 18*, 251-261.
- Leipzig, R. M., Hyer, K., Ek, K., Wallenstein, S., Vezina, M. L., Fairchild, S., Cassel, C. K., & Howe, J. L. (2002). Attitudes toward working on interdisciplinary healthcare teams: A comparison by discipline. *Journal of the American Geriatrics Society, 50*, 1141-1148.

References (cont'd.)

- Qualls, S. H., & Czirr, R. (1988). Geriatric health teams: Classifying models of professional and team functioning. *The Gerontologist*, 28, 372-376.
- Reuben, D. B., Levy-Storms, L., Yee, M., Lee, M., Cole, K., Waite, M., Nichols, L., & Frank, J. C. (2004). Disciplinary split: A threat to geriatrics interdisciplinary team training. *Journal of the American Geriatrics Society*, 52, 1000-1006.
- Satin, D. G. (1987). The difficulties of interdisciplinary education: Lessons from three failures and a success. *Educational Gerontology*, 13, 53-69.