Best Practices and Models of Geriatric Interprofessional Education and Teamwork: Implications for Newfoundland and Labrador

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Outline of Presentation

- **Examine**
  - Context for interprofessional education (IPE) in the US

- **Review**
  - Selected historical programs

- **Summarize**
  - Lessons from history for the present

- **Develop**
  - Some guidelines for IPE program content

- **Propose**
  - Implications and recommendations for Newfoundland and Labrador
Some Good News

- Recent Institute of Medicine (IoM) reports in the US supporting interprofessional education (IPE) and practice (IPP) in health

- 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).
- Challenges with combining IPE and work with older adults (“double jeopardy”)


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 (in Geriatrics) Programs (ITTG/P)

- **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 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
- Significant 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
  - Baldwin (1996)
  - Satin (1987)
Hartford GITT Findings
(Leipzig et al., 2002)

- **Attitudes toward working on IP teams**
  - Medical residents, advanced practice nursing students, and MSW students all support IPP as benefiting geriatric patients
  - Significant differences between MDs and NPs/MSWs with regard to leadership 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 vs. 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
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
Lessons Learned (Satin, 1987)

- **High priority**
  - IPE itself must be the highest priority 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
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
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.”
Some Guidelines for IPE Content Areas

- **Essential knowledge and skills for IPP**
  - Cognitive maps
  - Normative maps
  - Reflection
  - Toolkits
  - Goal-based health care
Some Quotations for Consideration

▪ “We don’t see things as they are; we see things as we are”
  ◆ Anaïs Nin

▪ “The real voyage of discovery consists not in seeking new landscapes, but in having new eyes.”
  ◆ Marcel Proust
Epistemology of Interdisciplinary Inquiry  
(Petrie, 1976)

- **“Cognitive map” of a profession**
  - Basic concepts
  - Modes of inquiry and observational categories
  - Representational techniques
  - Standards of proof
  - Types of explanation
  - What counts as a problem
  - General idea of what constitutes the discipline
Ontology of Interdisciplinary Inquiry
(Clark, 2006; Drinka & Clark, 2000)

- “Normative map” of a profession
  - Basic values
  - Modes of moral reasoning
  - Methods of resolving ethical dilemmas
  - Related to one’s core identity as a person and as a professional
Need for Reflection (Clark, 2009)

- **Focus on knowledge**
  - Concept of “decentering,” of becoming aware of viewpoints different from one’s own

- **Notion of “metacognitive competence”**
  - One is able to “think about one’s own thinking” as well as that of others

- **Encouraging reflection**
  - Journaling
  - Self-assessments
Contents of Professional Toolkit

- **Maps of a profession**
  - Cognitive map
  - Normative map

- **Models of professional functioning**
  (Qualls & Czirr, 1988)
  - Logic of assessment
    - “Ruling in” and “ruling out”
  - Focus of professional efforts
    - Acute medical vs. social and functional
  - Locus of responsibility for change
  - Pace of action
Contents of Teamwork Toolkit

- **Teamwork skills** (Clark, 2009; Hyer et al., 2001; Long & Wilson, 2001)
  - Communication
  - Conflict management
  - Leadership
  - Role negotiation
  - Problem-solving
  - Decision making
Contents of Teamwork Toolkit (cont’d.)

- **Teamwork expectations and beliefs**
  
  (Qualls & Czirr, 1988)
  
  - **Focus of group’s attention**
    - Outcome vs. process
  
  - Expectations about decision-making
  
  - Beliefs about interdisciplinary practice
Two Different Models or Paradigms of Health Care (Mold, 1995; Mold et al., 1991)

- Disease- or problem-based
- Goal-based
Disease or Problem-Based Model

- **Basic assumptions**
  - Ideal health defined by absence of health-related problems
  - Purpose of health care is to prevent or eradicate these problems

- **Characteristics**
  - All health problems are undesirable
  - Diseases are distinct from the individual
  - Depersonalization and fragmentation of care
  - Health care professionals are experts in defining problems and their solutions
Application of Model to Older Persons

- **Limits**
  - Does not take into account the normal aging process
  - Does not provide a model for achievable health

- **Need more open-ended model**
  - Sees “problems” as “challenges”
  - Admits of the positive effects of challenges
  - Emphasizes personal growth and development
Goal-Oriented Model of Health

- **Characteristics**
  - Health is defined by each individual and may be different at different times
  - Individual health goals should be determined by both individual and provider
  - Decisions regarding priority of individual’s health-related goals rest with the individual
  - Success is measured by whether the individual feels progress is being made in achieving goals
Goal-Oriented Model of Health

- **Requires assessment of**
  - Individual strengths and resources
  - Interests and needs
  - Personal values
  - Real and potential obstacles and challenges

- **Implications for interprofessional teamwork**
  - Supports collaboration with other disciplines to achieve individual’s goals
  - Provides overarching “mission” for the team to unite all disciplines
  - Makes team members become consultants to the individual
Implications for Newfoundland and Labrador

- Aging and chronic disease
- Healthy aging
- Rural context
- Team composition and focus
Implications for Newfoundland and Labrador (cont’d.)

- **Aging and chronic disease**
  - Rapid aging of province
  - Greater chronic disease burden

- **Healthy aging**
  - Multifactorial determinants of health
  - Health promotion at any health status
Implications for Newfoundland and Labrador (cont’d.)

**Context of rural practice** (Hunter, 1998; Jensen & Royeen, 2002; Kelley & MacLear, 1997; Minore & Boone, 2002; Slack et al., 2002)

- Large numbers of older adults
- Need to emphasize primary, secondary, and tertiary prevention
- Role of culture, health beliefs, and practices
- Broader definition of health, health care, and roles of professionals
- Serving the underserved and disadvantaged
Implications for Newfoundland and Labrador (cont’d.)

- **Community focus**
  - Determine needs of communities
  - Work with local populations on needs

- **Team composition and focus**
  - Blurring of traditional roles and responsibilities among professions
  - Wider array of team members (including paraprofessionals from community)
  - Members may be on more than one team
  - Need to address geographic separation
  - Use of technology to create “virtual teams”
Some Reflections and Recommendations

- Development of combined IPE focus
  - Interdisciplinary
  - Older adults
  - Health promotion
  - Rural

- Potential structures
  - Clinical teamwork
  - Research/intervention
Some Reflections and Recommendations

- **Potential benefits**
  - **Students**
    - Change traditional roles and expectations
    - Increased interest in careers in geriatrics/gerontology and rural/remote
  - **Older adults**
    - Improved active aging
    - Enhanced quality of life
  - **Province**
    - Community-government-academic partnership
Some Reflections and Recommendations

- **Potential challenges**
  - Connecting IPP and IPE
  - Triple jeopardy problem
    - Teamwork
    - Older adults
    - Rural
  - Sustainability
Some Final Questions to Ponder

- “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


References (cont’d.)

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