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Using Principles of Interprofessional Education to Transform Primary Care Practice

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Disclaimers

We have no financial conflicts of interest related to this talk.

Session Objectives

- Participants will articulate the complexity of practice redesign efforts.
- Participants will identify opportunities to apply IPE principles to practice redesign.
- Participants will consider evaluation strategies that measure impact on interprofessional team function as well as traditional patient outcomes.

Our Premise

There is increased recognition of the need for rapid transformation of practice models to promote interprofessional teamwork and improve outcomes. Partnerships between practice leaders and IPE educators may lead to more effective and sustained transformation that can impact patient-, staff- and learner-centered outcomes over time.

Background: The Case for Transformation

The importance of effective collaborative practice models to improve the experience of care, improve health, and reduce costs is well established.



Barriers to Change

- Traditional hierarchy and culture
- Financial and structural barriers
- Out-moded payment models must be overcome
- Practice leaders are often not versed in current interprofessional education theory, while IPE experts may not be integrated with practice

Jefferson Family Medicine Associates

This presentation describes ongoing work at Jefferson Family Medicine Associates, a large urban academic family medicine practice, to transform the care model and improve staff-, patient- and learner-centered outcomes



About Our Practice

- 45 faculty (42 physicians)
- 30 family medicine residents
- 1 geriatric fellow
- 2 sports medicine fellows
- 1 primary care research physician fellow
- 1 population health post-doctoral fellow
- 7 nurse practitioners
- 131 staff
- NCQA PCMH Level 3 status x 8 years
- 35,000 patients making over 80,000 visits annually
- Over 1,000 students annually, from Jefferson Medical College, the Jefferson Schools of Nursing, Pharmacy, Health Professions and Population Health and beyond
- 14 clinical sites all over Philadelphia, including outpatient practices, nursing homes, community partnerships, geriatric oncology, palliative care, and inpatient services

Methods: Our Interventions

- Leadership commitment to teamwork and transparency
- TeamSTEPPS for Primary Care to create a shared language around key team-working skills
- Roles and responsibilities of every member of the practice team have been critically reviewed and communicated
- Interprofessional workgroups (front desk staff, medical assistants, nurses, social work, public health, nurse practitioners, physicians, residents and students and IPE experts) are actively engaged in PDSA cycles to improve our practice

Patient and Family Advisory Council: PFAC

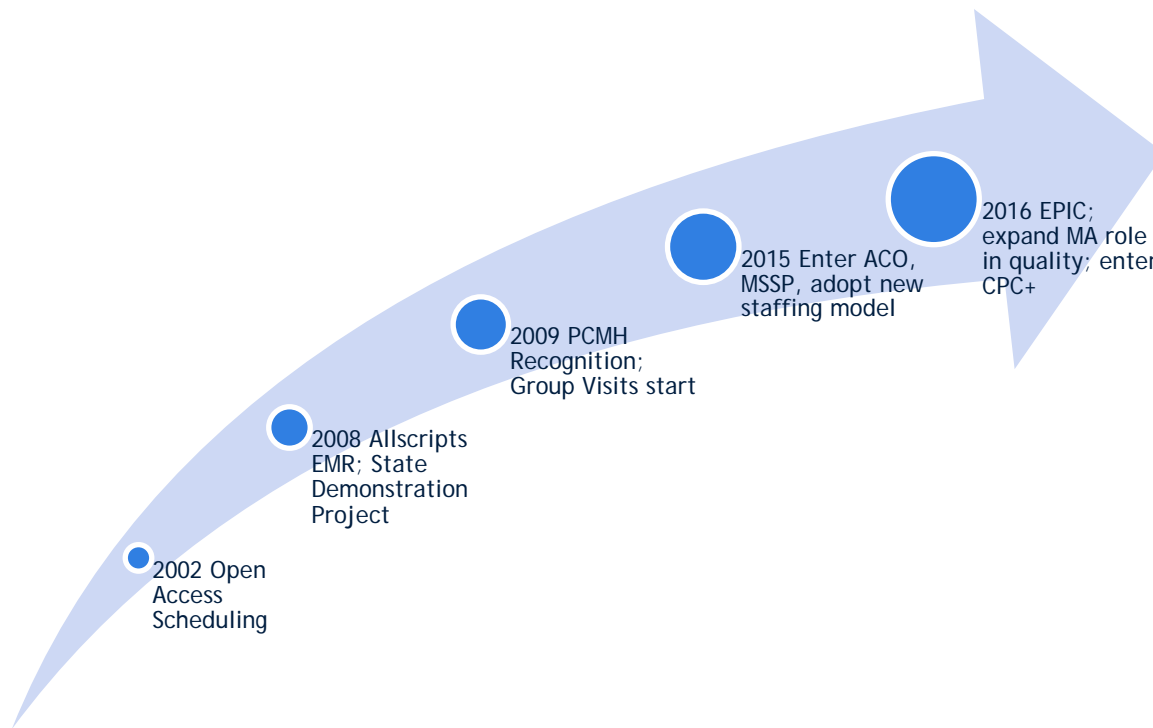


The Mission of Jefferson's Department of Family & Community Medicine's PFAC is to ensure that the point of view, perspective, and experiences of our patients and their families are not only heard, but integrated into quality improvements to ensure high-quality, patient-centered care.

The Institutional Environment

- Major organizational focus on move to population-based, value-oriented healthcare, which has led to:
 - enhanced care coordination, quality and data analytics resources
 - new health IT support
- New curriculum in quality and safety for staff, residents, and students
- Engagement with Medicare Shared Savings Program and Comprehensive Primary Care Plus PCMH demonstration projects

Timeline of Practice Transformation



Evaluation Methods

- Staff satisfaction and engagement surveys
- Patient outcomes/ quality metrics
- Patient satisfaction and perception of teamwork
- Assessment of learner knowledge, attitudes, and self-efficacy for sustained teamwork to improve quality.

Staff Satisfaction

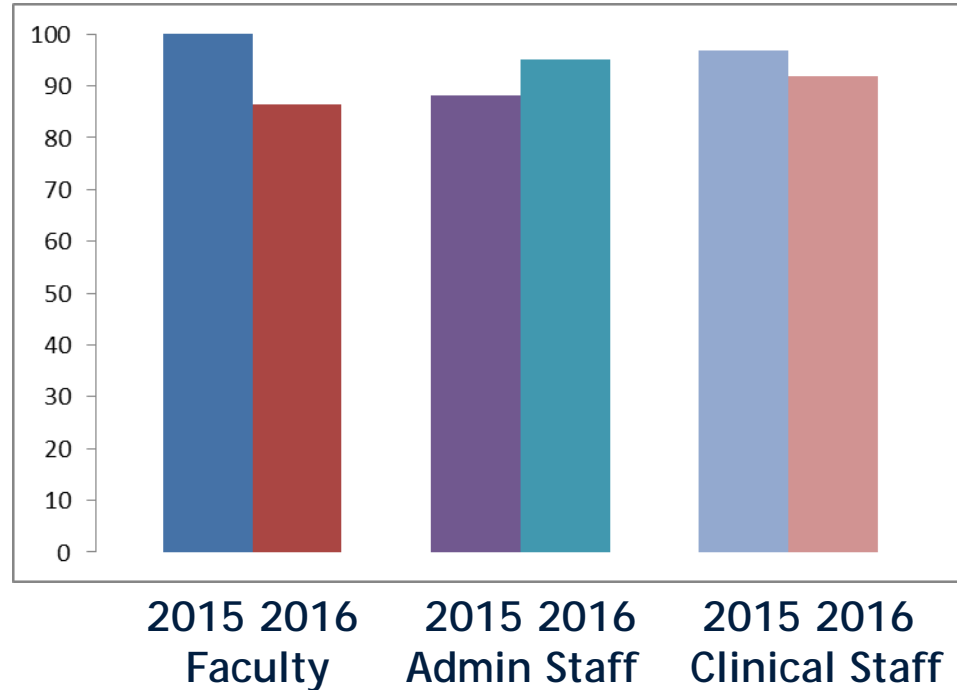
- Composite tool using validated items to measure satisfaction and burnout
- Developed and survey conducted by Randa Sifri, MD, Marianna LaNoue, PhD and Amy Cunningham, PhD (unpublished results)

DFCM Faculty and Staff Satisfaction Survey

- Initially administered June-July 2015; 89 responses
 - 40 clinical faculty
 - 17 administrative staff
 - 32 clinical staff
- Second administration: October-November 2016; 94 responses
 - 36 faculty
 - 20 administrative staff
 - 32 clinical staff
 - 5 did not indicate role

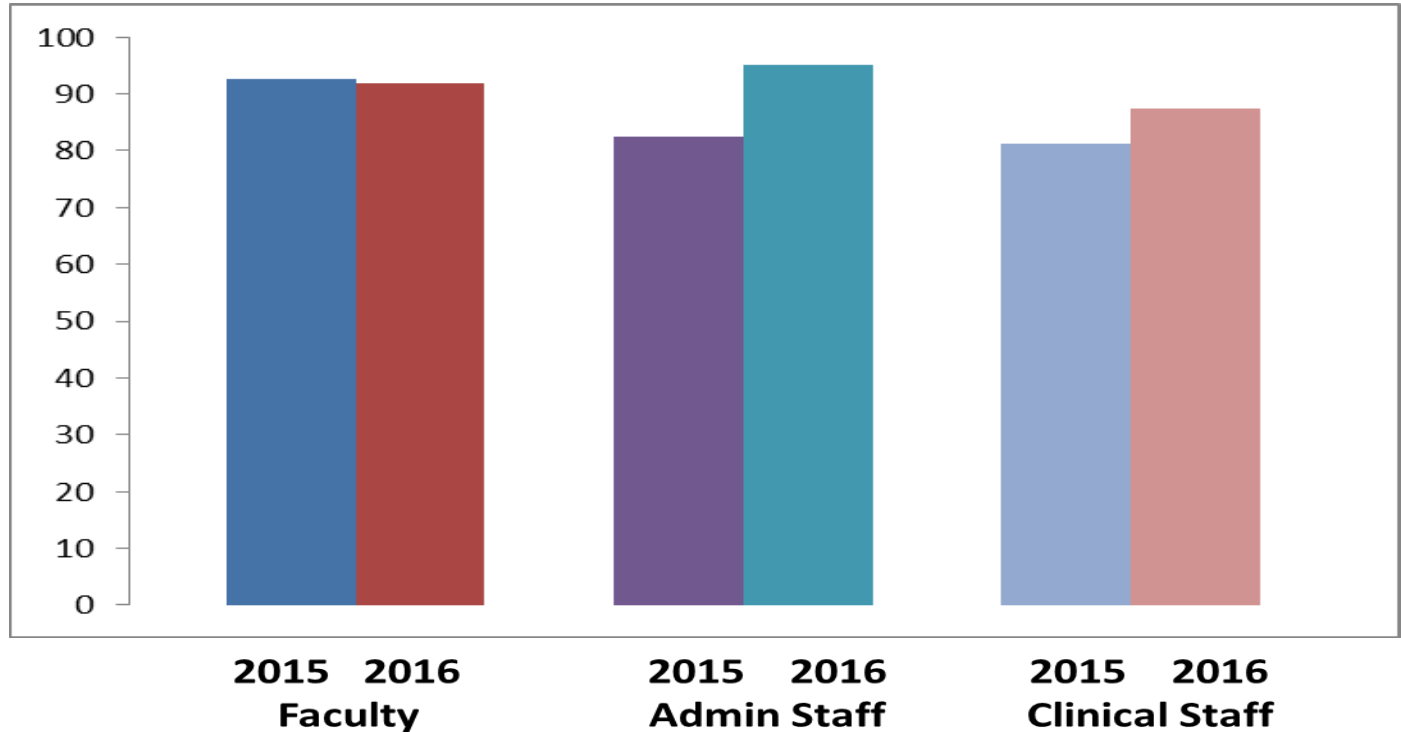
I like the things I do at work

% Agree or Strongly Agree



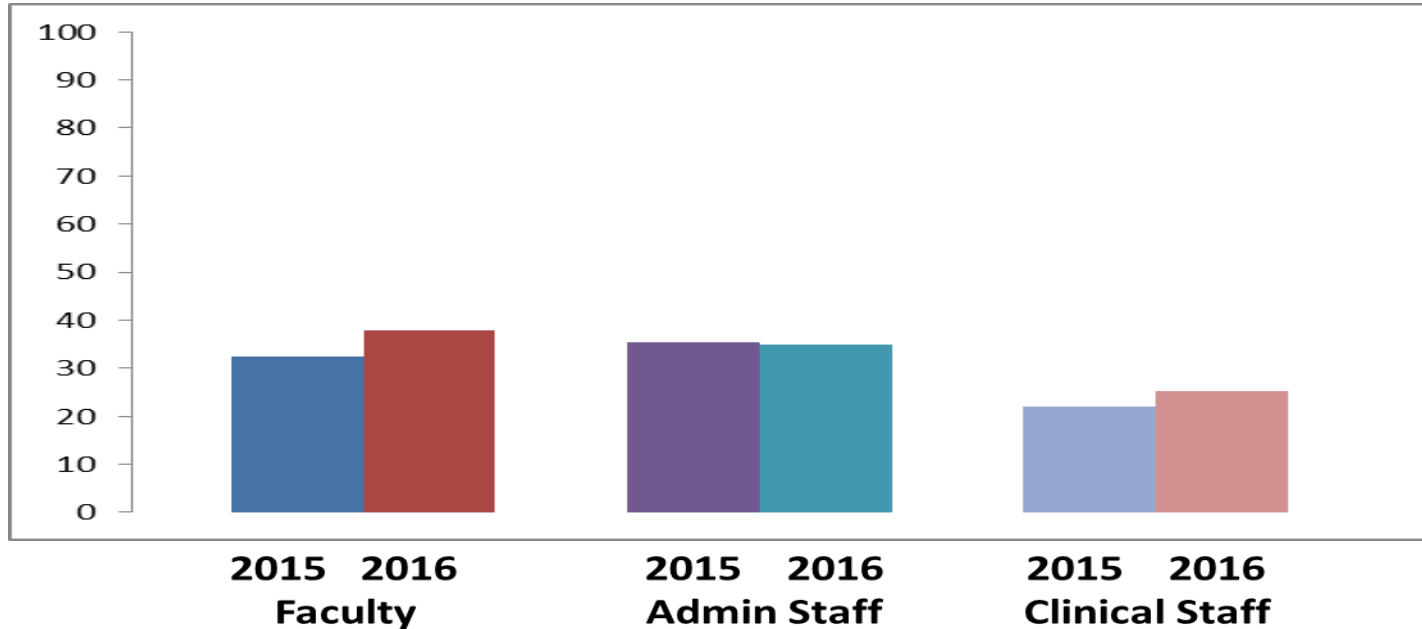
I feel that I am positively influencing other peoples' lives through my work

% Agree
or
Strongly
Agree



I feel burned out from my work

% Agree
or
Strongly
Agree



Role

Patient Oriented Outcomes: Satisfaction

- Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores - required by CMS for all practices
- “Top Box” scores - overall patient satisfaction with practice and provider

	% Very Satisfied with Practice	% Very Satisfied with Provider
June 2016	86.4	92.0
August 2017	87.2	92.3

Jefferson Teamwork Observation Guide Data

	Frequency	Percent
Mixed	13	8.6
Negative	10	6.6
Positive	108	71.5
Omitted	2	1.3
No Response	18	11.9
Total	151	100.0

- I felt as though in every instance I wasn't put off at all. They listened and answered my questions.
- They listened. Really listened. Sometimes they just talk over you or at you. But not here. Here they actually listened to me.
- Not much concern of the situation of the patient, indifferent. Avoid flexibility. Couldn't help get resources. Would be superficially nice but not actually helpful. They don't care because it isn't their suffering and it's not their pain.

Collins, LaNoue et. al. Unpublished Data, 2017

Patient Oriented Outcomes: Quality

	Controlled A1c	Colon Cancer Screening	Depression Screening	Pneumonia Vaccine
January 2016	64%	57%	11%	69%
August 2017	66%	58%	54%	74%

Composite Quality Scores from Major Commercial Payer:
Increased from Tier 5/ 66th % in 2015 to Tier 2/ 71st % in 2016

Learner Outcomes: Preliminary

- New resident and student curriculum outcomes to date include high satisfaction with the content and delivery of curriculum, and improvements in knowledge and self-efficacy for pilot groups.

Conclusions

- This work is complex and has required an extraordinary level of commitment from the entire practice and academic teams
- Progress has been incremental but significant, with steady progress across most metrics.

Ongoing Challenges

- Uncertain pace of payment reform
- Limited resources available within primary care
- Continued pressure to focus on volume of care to drive current revenue
- Change fatigue and burnout

In spite of the challenges...



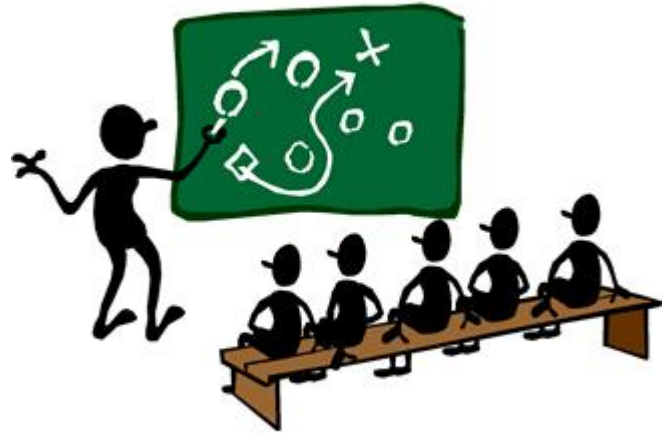
- Practice staff, learners, and patients appreciate the positive impacts of improved teamwork
- Engagement of interprofessional teams in continuing cycles of practice redesign and improvement is high

Next Steps

- Continue PDSA cycles with our interprofessional practice teams
- Focusing on the Quadruple Aim - Joy in Practice - for all team members
- Focusing on priority areas that will drive value-based revenue to relieve pressures on fee-for-service “old way” business model

Discussion

We believe this journey can serve as a model for practices and health systems seeking to redesign practice to support effective teamwork and improve outcomes through practice/ education partnerships



Questions



Jefferson Center for Interprofessional Practice and Education



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Jefferson Department of Family & Community Medicine



http://www.jefferson.edu/university/jmc/departments/family_medicine.html



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