

MEDICAL EDUCATION: PART I

DESIGNING AN INTERPROFESSIONAL TRAINING PROGRAM AND TEAM-BASED PRACTICE AROUND PCMH PRINCIPLES

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Patient Centered Medical Home (PCMH) principles have guided primary care redesign for the past decade¹. Many ambulatory educational redesign efforts are based on applying patient-centered principles to residency practices². Training in collaborative care models has been accepted as a goal by most major accreditation organizations, including the AAMC and the ACGME³. Despite evidence that training in interprofessional models improves outcomes for providers, trainees and patients, few longitudinal interprofessional training programs exist^{4,5}. With funding from the Human Resources Services Administration we conceived and built a longitudinal interprofessional training program with three goals: improving interprofessional education, creating a resident-led collaborative care practice, and increasing the primary care workforce through role modeling and mentoring. In this report we describe how our training program, the Improving Access, Care, and cost through Training (IMPACcT) practice, promotes realization of PCMH principles of team-based care, care coordination, quality and safety emphasis, improved access and continuity, and a whole person orientation.

Team-based care in our practice begins with a structured team-based huddle prior to each half-day clinical session. The huddle is designed to enhance the efficiency of each visit by assigning care team members to specific roles in pre-visit planning, allowing each to work to the top of their license. Team members “scrub” charts to prepare for the huddle, which is led by the medical office assistant (MOA). Residents introduce patients indicating key tests to be done by MOAs. Pharmacy students identify medication-related problems (polypharmacy, medication interactions) as well as needed vaccinations based on the patient’s age and risk factors. Physician Assistant (PA) stu-

dents note recommended preventive healthcare and cancer screening modalities. Psychology team members highlight behavioral health needs and recommend strategies to optimize patient adherence. Finally, the structure of the patient visit is ascertained, assigning appropriate team members (including trainees) roles in the allotted visit time to maximize visit efficiency. Care coordination is primarily facilitated by collocation of a patient access coordinator in the team office and inclusion of the coordinator in all clinical activities including the huddle. The coordinator serves as scheduling navigator for patients, calling to remind patients of upcoming visits, and addressing scheduling and insurance barriers to facilitate appointments. The coordinator participates in the huddle as well as more detailed clinical discussions to meet patient care needs. As a participant in the clinical discussion, the patient access coordinator schedules follow up visits (primary, specialty, and testing) at the time of the visit, balancing timely access, continuity, and coordination across care transitions.

To capitalize on the talents of our interprofessional trainees, we have developed a quality and safety initiative focused on collaborative medication reconciliation. Team medication reconciliation begins with pharmacy team members identifying patients with complex medication regimens (e.g., polypharmacy, recent discharge, adherence barriers, high-risk medications) and then completes medication reconciliation for identified patients and with the support of other team members as needed (e.g., with the psychology student to help address adherence issues). Medication discrepancies, recommendations addressing medication-related problems, reported side effects, or adherence problems are discussed with the team and a revised medication plan is developed and

continued on page 2

MEDICAL EDUCATION: PART I (continued from page 1)

reviewed with the patient. Given the evolving importance of avoiding polypharmacy, a proton pump inhibitor deprescribing initiative was started in the last year, supported by the Institute for Healthcare Improvement⁶. All patients taking proton pump inhibitors are identified by the pharmacy student during the huddle. If the patient meets safety criteria for potential de-escalation or deprescribing, options are discussed with the patient and clinical team until a mutually agreeable plan is reached. To date, 32 of 63 patients screened have had proton pump inhibitors deprescribed, a total decrease from 10.2% to 8.1% of the practice population.

Improved access in the IMPACcT program is facilitated through practice redesign. Extended hours are available one evening a week. Attending physicians have open hours to allow continued patient access during those times that residents are unavailable to support pre-visit planning and care coordination. Previsit confirmation calls by the patient access coordinator allow timely cancellation of appointments that are no longer needed, decreasing the “no-show” rate and thus enhancing appointment access. As follow up appointments are scheduled by a team member involved in clinical discussions, physician continuity is enhanced significantly compared with the conventional “front desk” scheduling model utilized in our traditional resident practice.

An orientation to comprehensive care is achieved through the clinical huddle and the “clinic-within-a-clinic” structure which allows all team members to gain familiarity with the patient panel. Patient needs are

anticipated based on past visits and the patient’s history, and visits are arranged to meet these needs. For instance, a patient with a complex medication history receives extended medication management with the pharmacy faculty. A patient with depression may be scheduled to see the psychologist and the physician in a joint visit. A PA or medical student will see patients for annual physicals and focus on preventive health needs as well as any acute problems or concerns. Social workers and case managers are engaged during the huddle to plan an approach to the visit before the patient arrives to the office. Given the resident practice operates in a 4+1 model of inpatient and outpatient responsibilities, patient needs which extend beyond the visit are discussed at the end of the week during a team sign-out, so that any unresolved issues and questions can be passed along to incoming team members the following week.

The collaborative care model in the IMPACcT practice was built by embedding PCMH principles into the structure of our team and approach. A creative approach to utilizing the available space, deploying team members, scheduling practice visits, has allowed us to weave care coordination and access into the fabric of our practice. Designing our huddle and team signout with specific roles for trainees from various professions creates an inclusive yet structured approach to team-based care and allows for attention to the whole patient. Capitalizing on the strength of the pharmacy team allows focus on medication reconciliation and deprescribing as key safety and quality initiatives. Our goal is to inspire trainee graduates ground-

ed in interprofessional education and high-functioning collaborative care to pursue careers as leaders in primary care redesign.

References

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