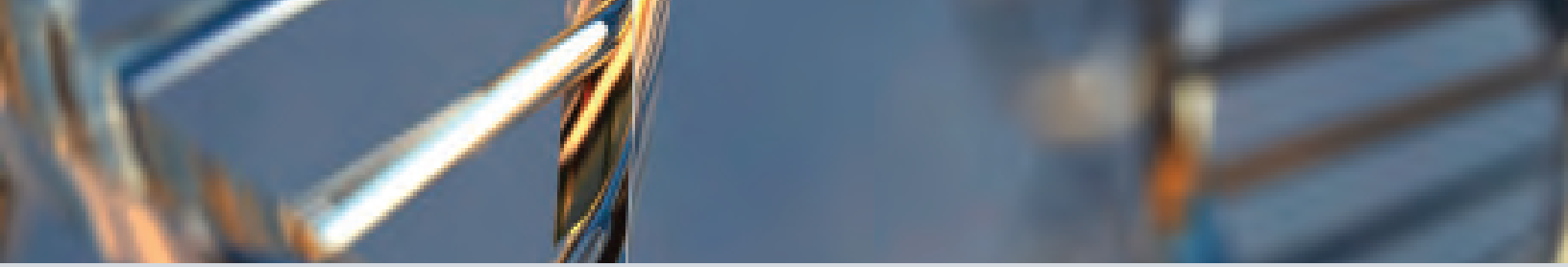
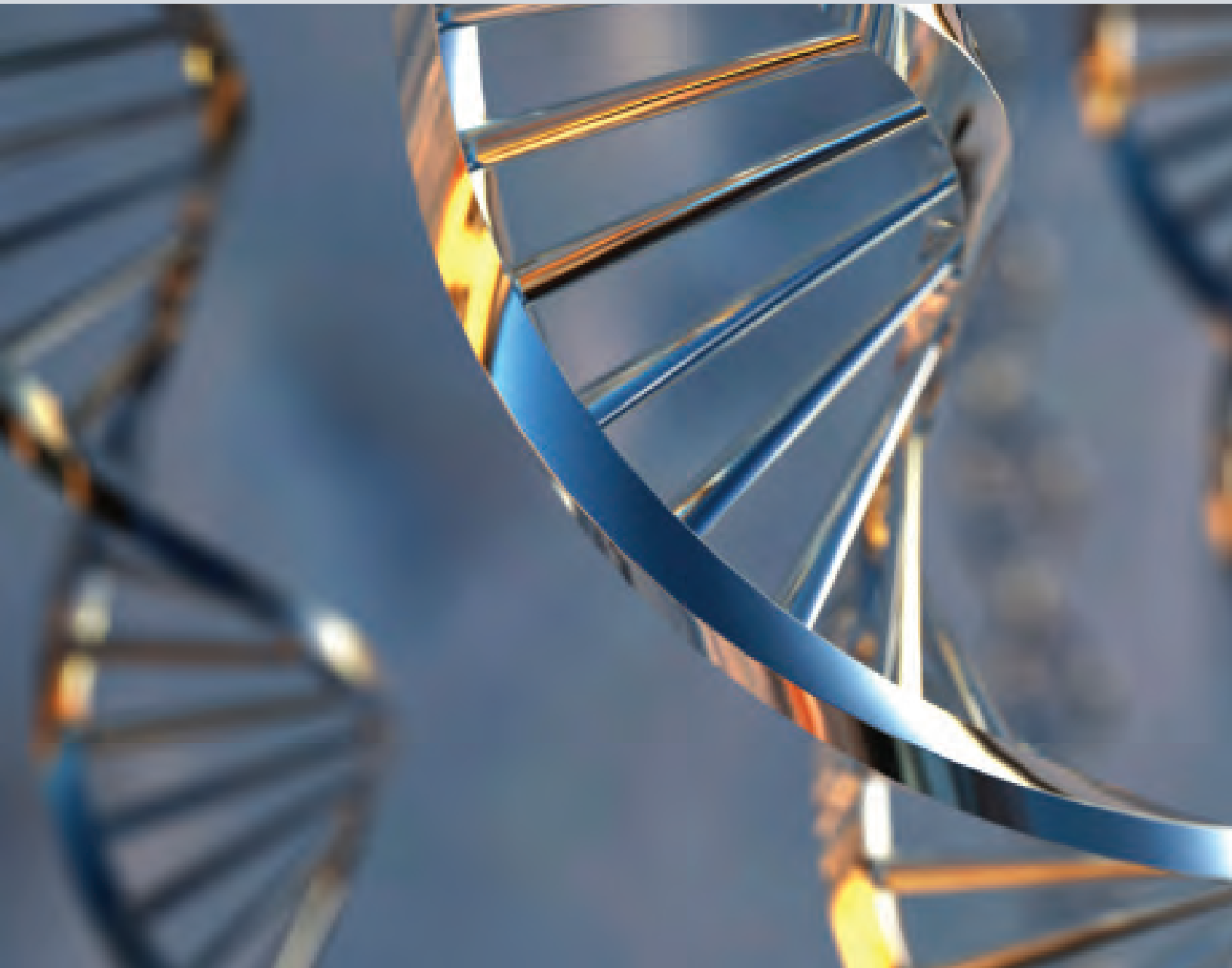


Wharton
University of Pennsylvania

THE WHARTON HEALTHCARE QUARTERLY

SUMMER 2016
VOLUME 5, NUMBER 3



STRONGER THAN THE SUM OF OUR PARTS: A COLLABORATIVE BALANCE: INTERPROFESSIONAL EDUCATION IN CLINICAL SETTINGS - PART 5

Last summer we embarked on a Learning Assessment of an independent academic medical center (AMC). Like many AMCs, their model included separate reporting structures for medical education; nursing education; performance improvement; patient experience; and IS training; with learning technologies and leadership training grouped with diversity and patient language services. The structure lacked visible leadership for educating other clinical professions, such as therapy and advanced practice providers. Continuing to engage leaders across the system in reviewing proposed options, we helped the health system make structural changes to simplify the learning organization. Specifically, to consider an interprofessional approach, by combining almost all of the previously siloed structures for clinical professional education. As they began to commit to implementing an interdisciplinary model, strong feelings surfaced regarding authority over technical aspects of clinical learning — topics like pathways, protocols, and new clinical technologies. The approach struck a chord, raising the question — what should remain within each profession and what should be done in conjunction with others?

Education to promote interprofessional collaboration is a powerful strategy for ensuring the sustainability of patient-centered interventions and outcomes. This was a primary finding in a recent report we authored in partnership with the Robert Wood Johnson Foundation, entitled *Lessons from the Field: Promising Practices in Interprofessional Collaboration.* Having everyone on a care team understand their own role AND the role that other members play is fundamental, yet this basic principle is often not achieved. As we learned in the example above, while the need for integration across disciplines is becoming more broadly accepted, ceding discipline-specific ownership of education constitutes an identity risk. The future of any profession is determined in part by how its workforce is educated today, but how can academic medical centers and health systems reinforce the role and value of each profession, in the context of the other professions with which they will ultimately work?

We've seen several organizations whose models have successfully approached this dilemma, using governance that promotes role clarity to strengthen discipline-based leadership of learning. We describe two here.

Learning Something New Together

Although the University of Pennsylvania Health System has had interprofessional unit-based clinical leadership teams (UBCLs) for nearly a decade, the teams can't always provide the acute focus needed to develop new programs. When the system began developing SOAR (Supporting Older Adults at Risk), a new interprofessional geriatric care model, leaders knew they would have to create temporary structures to support it.

The purpose of the SOAR program is to build a culture of geriatric care on medical units in a hospital without a geriatric medical practice. This means, for example, helping to ensure that older patients' functional and mental condition does not decline over their hospital stay.

Although the SOAR interventions anchor on Geriatric Resource Nurses, or GRNs, there are roles for physicians, therapists, pharmacists, social workers, nutritionists, and discharge planners as well. GRNs required the most education, as each became certified in geriatric competencies, but all unit team members received training in concepts like medication management for older adults and delirium risk. Team members also needed to keep up

Contributors:
Carey Huntington Gallagher and Jennifer Tomasik

To learn more about Carey and Jennifer, click here.

STRONGER THAN THE SUM OF OUR PARTS: A COLLABORATIVE BALANCE: INTERPROFESSIONAL EDUCATION IN CLINICAL SETTINGS - PART 5 *continued*

with the processes that SOAR was piloting — ensuring efficient rounds that incorporated the geriatric perspective or implementing new pathways.

SOAR leadership, based in Nursing, was tasked with developing a temporary structure that would overlay the existing interprofessional forums to provide oversight and support for program education. They put in place two tiers of interdisciplinary touch points — an Interprofessional Collaborative Practice Leadership Group (IPCP) and monthly meetings on each unit focused just on the SOAR program. IPCP leadership shaped the pathways, advised regarding education opportunities, and drove engagement for each discipline. Unit meetings were used to disseminate information and gather feedback. Program leadership leveraged UBCL meetings to align SOAR with initiatives across the health system.

In this way, SOAR leadership ensured that all disciplines had a strong voice in the shaping and implementation of education for the program, helping units see the interventions not as "Nursing's initiative," but as their own work. Through dedicated attention to not only the right structures, but the agendas of each group, Nursing was able to bring SOAR to life and engage interprofessional leadership of learning.

Patient-Centered Governance

Some health systems have formed interprofessional leadership groups at the system level that function at the heart of all clinical decision-making. This strategy supports creating the understanding that interdisciplinary decision-making is "business as usual" and dissolves silos over time. For example, since 2005 the Patient Care Governance Council (PCGC) at Cincinnati Children's Hospital Medical Center has enabled every profession to come together in a shared governance structure.

While at Cincinnati Children's developing the Robert Wood Johnson Foundation report, we had the opportunity to meet with physician, nurse, and educational/performance improvement leadership represented within the PCGC. The four shared how the PCGC is working to create a culture of interprofessional collaboration at Cincinnati Children's, where hard decisions, such as shaping education across all disciplines, are made within this interprofessional body. Each profession is able to see itself in this model, maintaining its identity while still finding ways to be part of a team and to advance the IP Practice Model. Lisa Adamson, BSN, RN-II, CNRN, Chair of the Nursing Professional Practice Council at the time, shared how the PCGC "Enlightens you outside your scope, helping each member to understand the roles and responsibilities of those outside their own profession, while strengthening their own professional voice."

The PCGC rests on top of individual professional identity groups, allowing the system to strike a balance in clinical leadership. While the PCGC structure is well-conceived, it is the practice of working through clinical questions that has made the difference, supporting leaders to establish relationships and build trust.

As health systems better understand tomorrow's demands for strengthening the work of interdisciplinary care teams, interprofessional support and alignment of clinical education will become even more important. Creating active governance bodies that build trust and shape learning can help different disciplines' voices be heard without challenging ownership and identity of clinical education.

For more information on this topic or related materials, contact CFAR at info@cfar.com or 215.320.3200 or visit our website at http://www.cfar.com.