

The Importance of Interprofessional Practice and Education in the Era of Accountable Care

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In order to succeed in today's health care environment, interprofessional teams are essential. The terms "multidisciplinary care" and "interdisciplinary care" have been replaced by the more contemporary term "interprofessional practice and education" (IPE), which occurs when individuals "from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes." This commentary discusses new models of care, team members who contribute to IPE, and incentives and challenges.

The landscape of health care delivery has changed considerably with the passage of the Patient Protection and Affordable Care Act (ACA). The federal government has moved to incentivize health care providers to improve quality and patient outcomes by tying reimbursement to cost savings, quality measures, service, and efficiency. With the patient at the center of health care, value-based care is now replacing volume-based care as we move towards a pay-for-performance structure. In addition, the Centers for Medicare & Medicaid Services (CMS) has implemented pilot programs to encourage providers to create interprofessional care teams. These teams are primarily designed for the purposes of coordinating care and education for their patients; improving overall patient health; promoting self-care; identifying and treating health conditions sooner rather than later; and helping patients effectively manage chronic health conditions such as congestive heart failure, chronic obstructive pulmonary disease (COPD), heart disease, diabetes, and asthma. Third-party payers are beginning to follow suit with similar goals and incentives. These new models of patient care include accountable care organizations (ACOs) and patient-centered medical homes (PCMHs) that utilize electronic medical records (EMRs) and focus on population health [1].

In many contexts, the terms "multidisciplinary care" and "interdisciplinary care" have been replaced by the more contemporary term "interprofessional practice and education" (IPE), which occurs when individuals "from two or more professions learn about, from and with each other to enable effective collaboration and improve health outcomes" [2], rather than working in silos. Mutual respect among the professions is critical. These boundary-spanning individuals

help to "build relationships, interconnections and interdependencies in order to manage complex problems" such as health care services [3]. IPE has become an important topic in the field of today's health care, and it impacts how we train health professionals to participate on care teams. In order to succeed in today's health care environment, interprofessional teams are essential [4].

Accountable Care Organizations

The health care workforce has changed in recent years, and it will continue to evolve, with an emphasis on the integral role of primary care and interprofessional teams. There will also continue to be a focus on quality, outcomes, and preventive services for populations served by ACOs. One of the ways the ACA seeks to reduce health care costs is by encouraging physicians, hospitals, ambulatory care organizations, PCMHs, home health agencies, pharmacies, and other health care organizations to form ACOs. For example, ACOs participating in the Medicare program build networks of providers who work together to coordinate services and education and to ensure high-quality care for Medicare beneficiaries. Financial incentives are made available to ACO providers for avoiding readmissions, preventable complications, and duplicate services; these incentives come in the form of bonuses and shared savings. Overall, ACOs hold providers accountable for the health of their patients, incentivize them to work cooperatively and efficiently, and encourage them to save money by monitoring the care of their patients between and among providers [1, 5].

Patient-Centered Medical Homes

PCMHs are designed to achieve several goals: to provide care that is delivered in a well-coordinated, cost-effective manner; to involve patients in decision making; and to provide access to patients' health information through an EMR. By utilizing these processes, PCMHs aim to improve patient outcomes and satisfaction. PCMHs often consist of an interprofessional care team led by primary care providers [1]. An

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ambulatory practice may become a medical home and may also be a part of an ACO. Some ACOs include attainment of PCMH status as a metric on their incentive dashboards, but there is currently no additional reimbursement from CMS if a practice is recognized as a PCMH. However, practices are monetarily incentivized by private payers. Currently in North Carolina, there is only 1 payer that provides incentives. Others have said that they will start to include incentives with their quality metrics but have as yet failed to bring such a program to market (personal communication with Jennifer Foreman, director, Greensboro Area Health Education Center, Center for Quality Improvement; December 2015).

The Interprofessional Team

It has been quickly recognized that physicians cannot provide all of the clinical and educational services that patients need in the new models of care. Instead, we must re-engineer the system of care in physician practices and ambulatory facilities to help patients and teams become successful. Interprofessional teams include physicians, nurses at different levels, certified medical assistants, dietitians, nutritionists, pharmacists, physician assistants, social workers, mental health workers, health navigators, health

coaches, community health workers, exercise physiologists, and quality improvement and informatics specialists. In a grassroots approach, patients and family members are also being added to advisory boards, where they are contributing to care and best practices for patients and their communities [6-10]. It is recognized that teamwork and shared values help to break down walls and convert fragmented care into integrated care. Ultimately, interprofessional teams that leverage information, experience, technology, and a culture of teamwork provide value for patients and families [5].

Incentives for Interprofessional Teams in ACOs and PCMHs

Incentives in an ACO environment strongly encourage collaboration among the members of an interprofessional team. Care coordinators often orchestrate patient care and promote communication among the care team. The patient is considered to be at the center of care, and the team provides services, education, and coaching to help the patient achieve optimal outcomes through best practices, clinical decision-making tools, and education. Team members have opportunities to interact and communicate with one another on a regular basis for consultation and education. When and

how they communicate is extremely important for success; some teams meet daily or weekly to review difficult cases and to gather input from the entire team. The EMR is also used to communicate and share responsibility for patient care across the care team.

If an ACO participating in the Medicare program reaches its targeted goals by helping their population of patients succeed with better health outcomes, improved satisfaction, and reduced cost for services, then the ACO can qualify for bonuses and shared savings from the Medicare program [1]. At present, the ACO model rewards closing care gaps but does not really penalize practices for failing to do so. Some payers are also pushing to have practices complete comprehensive preventive assessments and to close care gaps by having patients get needed services, such as mammograms and colonoscopies, in return for incentives (personal communication with J. Foreman; December 2015). Thus it is in the best interest of ACOs and PCMHs to have well trained, well organized care teams comprised of members practicing at the full scope of their licenses. These teams can be nimble

and innovative when it comes to customized care and services for high-risk, complex patients who require costly care.

When team members rely on one another, teach each other, and have the opportunity to practice in a highly successful environment, this usually brings great individual and team satisfaction. When they feel a common purpose, they inspire and motivate one another. ACOs and PCMHs that provide interprofessional team members with financial and non-financial incentives may achieve even greater satisfaction among the core team. However, organizations that overemphasize financial incentives, without a strong focus on fostering and nurturing a values-driven culture, will limit their overall potential and success [5, 10, 11].

Challenges and Disincentives for Interprofessional Teams

Interprofessional care teams that are a part of ACOs and PCMHs also face obstacles. Although interprofessional teams are highly recommended for patients, not all health care professionals prefer to work on teams. ACO and PCMH

leaders often report that communication among team members is their toughest daily challenge. This is especially true when teams are caring for complex patients who have multiple providers and customized needs. Communication and work on EMRs can also be very taxing and time consuming, especially when health care providers are under pressure to meet patient and organizational goals and deadlines for reimbursement. Finally, many social determinants of health can be barriers or challenges for team members. For example, patients without access to basic needs like air conditioning (critical for a COPD patient) or a refrigerator (to store medication needing temperature control) can be challenging for the team and the organization. This can be very discouraging for a team member who has a great desire to see patients improve but is unable to provide these items (personal communication with Rhonda Rumble, director, Triad Healthcare Network care management; November 2015) [12].

The emphasis on population health, with the expectation to focus on all patients registered in the practice—not just those who come for appointments or those who are the most successful or motivated, can be another challenge for some team members. This “panel” population health is different from “geographical” population health, which reaches out to all patients in a set region and aims to address social determinants of health and needs at a community level. The ideal ACO model is a blend of both, with a move toward what is called an accountable community of health [11, 12-15]. Additionally, reaching out to patients in their environment rather than waiting for them to come to the office is a significant change for team members, and not all team members are comfortable with this shift.

Promoting the Interprofessional Team in Health Care

Groups that work as a team need to train as a team. Continuing education for the entire team, not just individuals based on their disciplines, is highly recommended to promote professional development and esprit de corps. Ongoing professional development is key and also serves as an incentive. In recruiting future professionals who want to be a part of team-based care, we need to provide excellent clinical experiences for the various students at our ACO and PCMH sites. Maintaining ongoing relationships with interprofessional collaborative teams within precepting sites is crucial, as is building and sustaining relationships with clinical practices that serve as learning laboratories for interprofessional students. Rewards and incentives, such as ongoing professional development and stipends, help to recognize these sites and preceptors who are demonstrating modern health care [4, 10, 11, 16].

Examples of Interprofessional Collaboration Benefiting ACOs and PCMHs

The North Carolina Area Health Education Centers (AHECs) have numerous initiatives across the state that

demonstrate the use of IPE. For example, 9 regional AHECs across the state provide coaches to assist primary care practices of all sizes in implementing and sustaining the quality improvement team, analyzing workflows, implementing and meaningfully utilizing EMRs, and assisting with recognition programs. Also, many North Carolina AHECs have been working with ACOs across the state.

In another example, the North Carolina AHEC program used a “train the trainer” model to deliver a 1-day, statewide, continuing interprofessional education summit for all continuing education professionals and faculty within AHEC. The pilot initiative, which included the summit, was followed by live webinars for continuing education professionals and faculty to teach participants how to design, deliver, and evaluate future IPE programs across the state.

The newly developed North Carolina AHEC primary care team e-learning series and curriculum focuses on training non-licensed staff who are members of the care team but may have limited opportunity to participate in continuing education programs. The online modules and certificate program cover topics such as motivational interviewing, health literacy, basic chronic disease management, population health, and the role and responsibilities of the care team.

The I3 Population Health Collaborative has gone through several iterative stages over the past 11 years in working with physician residencies in primary care across North Carolina, South Carolina, Virginia, and Florida. This program aims to promote chronic disease management, improve performance in practice, establish medical homes with residents practicing in the health care of the future, and conduct quality improvement projects around the Institute for Healthcare Improvement’s Triple Aim of cost, quality, and service.

Since 1990, the North Carolina AHEC program, with funding provided by the North Carolina General Assembly, has assisted nursing schools in developing new clinical settings and experiences. In support of recommendations from the National Academy of Medicine’s report *The Future of Nursing*, AHEC has funded recent proposals from nursing schools to develop new interprofessional clinical learning experiences in which nursing students train with students from 1 or more other health care disciplines.

In 2014, academic leaders from High Point University, North Carolina A&T University, and the University of North Carolina at Greensboro (UNCG) established the Triad Interprofessional Health Education Collaborative. The goal of this group is to develop high-quality IPE experiences for health professional students including nursing, physician assistant, pharmacy, physical therapy, and social work students. Greensboro AHEC has provided ongoing consultation and assistance to this collaborative.

Lastly, North Carolina AHEC has partnered with the UNCG Department of Public Health Education to support the UNCG Health Coach Certification, a blended learning program that entails a 30-hour training program and quali-

fyng exams. On completion of this program and exam, participants earn a Certified Health Coaching certificate.

Conclusion

IPE teams have found their place in health care. Teams do not replace the physician-patient relationship, but rather enhance it—creating a more comprehensive, efficient, and tailored health care experience. We need to continue to promote, develop, and nurture collaborative teams that contribute to the successful health outcomes of our patients and community members. As part of its mission, the North Carolina AHEC program is working to help shape the collaborative culture and IPE learning environment of the future. Given the complexity of today's health care environment, no single discipline is equipped to direct the multitude of providers who make up the care team [10]. Hopefully, the new models of patient care involving interprofessional teams will help ameliorate the fragmented care that plagues our health care system today. NCMJ

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