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The UNM HSC Inter-professional Education Team

UNM HEALTH SCIENCES CENTER | IPE Interprofessional Education

THE INSIGHT

August 2014 Volume 2014 – No. 4

Health Equity: Introduction to Public Health for Health Professions Students

Cynthia Arndell, MD, FACP

Every year, since 2010, we introduce all incoming medical and physician assistant students to the communities they will serve in the greater Albuquerque Metropolitan region through the Health Equity: Introduction to Public Health course. This course has been in place for 5 years—piloted in July 2009.

Starting medical and physician assistant education with the course, Health Equity: Introduction to Public Health, as opposed to anatomy, signals students to the value our Health Sciences Center places on its mission statement—Vision 20/20, "Our state will make more progress than any other state in improving the health of our communities by 2020 through education, research and service."

Course Goals

The overarching goals of this 40 hour course are to: 1) create a framework for understanding health and illness from a socioecological perspective, 2) lay the groundwork for public health principles that can be reinforced throughout students' education, 3) introduce students to the communities they will be serving and, 4) introduce students to community-minded faculty that can serve as mentors throughout their education.

Multifaceted Approach to Learning

The course implements a multifaceted approach to learning which includes large group interactive sessions, small group faculty facilitated case-based sessions, and community engagement activities. Students are divided into small groups of 6-7 and remain in these groups throughout the entirety of the course. Each student group is assigned to 2 faculty facilitators and a community center in Albuquerque.

Community Engagement

The community centers represent a wide variety of geographic and demographic population characteristics. Over the past three years, Isleta Pueblo has been included as one of the community sites.

Course participants are introduced to social determinants of health—how socioeconomic status, educational level, ethnic background and environmental factors can positively or negatively impact the health of individuals and populations. Using online resources, student groups are then given the opportunity to research the demographics of the communities they are assigned to; exploring rates of teen births, high school dropout rates, chronic disease burden and poverty levels, among other health indicators.

Using a structured windshield survey, students drive and walk around their assigned communities and assess the deficits and strengths of the community; i.e., the number of green spaces, access to healthy food choices, the condition of housing, transportation, and pedestrian safety. A great deal of time is allotted throughout the course to enable students to engage in community center activities with children and seniors, interview residents living in the community as well as community center staff and directors. Throughout the course, students meet in their small groups with faculty facilitators to reflect on their community experiences and apply public health principles to case-based public health contemporary issues.

The course culminates with each student group presenting a poster of their assigned community to faculty and community center leaders.

Community Misconceptions Transformed

Throughout the years, students and faculty alike, rate the course very highly with student comments consistently reflecting how the course changed their misconceptions of Albuquerque communities; how it broadened their focus of

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their role as a future health professional in caring for individuals and populations; and how understanding the importance of the impact of social determinants on the health of individuals and populations can improve health outcomes.

This Year Was Different Though!

16 new pharmacy students started their education 3 weeks early to participate in this course. The results were remarkable—more attention was paid to student team dynamics and both faculty and students acknowledged the wonderful contributions and perspectives that the pharmacy students brought to the course. Multiple medical and PA students and faculty asked us why we had not included pharmacy students before now!

In our endeavor to implement more opportunities for interprofessional education, we realize that this course provides a great venue for students from across disciplines to learn about the communities they are serving and begin to think in the broader context of how to address community health priorities as a team.

Our vision is to expand the course to include all incoming pharmacy students as well as students from other professions. We also envision developing an interprofessional longitudinal community-engaged curriculum to create a more sustainable and meaningful presence in the community.

In partnership with our community members, we believe that we can truly fulfill our HSC Vision 20/20 mission statement and improve the health of our New Mexico communities.

IPE Active Work Groups at UNM HSC

Now that several work groups have been formed as an outcome of last May's IPE retreat, we invite you to considering working on a work group of interest, or perhaps you envision a new group for a future practice or course you would like to see become interprofessional. The IPE team stands ready to assist you.

The following list of the work groups and their contacts are provided if you would like to reach out to one or more of them.

For those of you who have already joined an IPE work group, thank you for your continuing support and actions to further IPE at the HSC. *The IPE team*

Community Engagement

Contacts:
Cindy Arndell; Loren Kelly
(Contact for schedule/location)

Joe Anderson
Cindy Arndell
Michelle Bardack
Chris Camarata
Paulina Deming
Anthony Fleg
Loren Kelly
Eric Quintana
LeeAnna Vargas
Betsy VanLeit

Ethics and Professionalism

Contact: Catherine Combs
(Contact for schedule/location)
IPE Team Liaison: Betsy VanLeit

Catherine Combs
Denai Forrest
Donald Godwin
Elizabeth Greer
Mary Jacintha
Amy Robinson

Geriatrics

Contact: Shelley Modell
(Contact for schedule/location)
IPE Liaison: Betsy VanLeit

Melanie Dodd
Yvonne Ellington
Shelley Modell
Kristen Ostrem
Traci White
Betsy VanLeit

Health Policy

Contacts:
Nancy Ridenour
Lynda Welage
Thomas Williams

Patient Safety & Quality Improvement

Meets: 2nd Monday monthly, 3:30-5 pm
Location: Dom West 3010
Contact: Dan Stulberg
IPE Team Liaisons:
Cindy Arndell; Loren Kelly

Cindy Arndell
Mark Holdsworth
Loren Kelly
Judy Kitzes
Carolyn Montoya
Joe Poole
Dan Stulberg
Herica Torres

Service Learning

(Student-Led Community Service)
Contact: Kyle Leggott
(Contact for schedule/location)
IPE Team Liaison: Michel Disco

Michelle Bardack
Lee Danielson
Michel Disco
Megan Eckstein (Toon)
Kyle Leggott
Paul McGuire
Patrick Rendon
Gary Smith

For list updates or to request support for a work group, please contact: IPE-Office@salud.unm.edu.

IPE TEAM:
Michel Disco, Betsy VanLeit, Cindy Arndell, Loren Kelly, Krista Salazar

IPE Work Group Summaries

IPE Ethics & Professionalism—Meeting Summary for July

Cathy Combs

Attended: Donald Godwin, Cathy Combs, Dr. Jonathan Bolton, Dr. Anne Simpson

Dr. Simpson gave an overview of the Ethics Certificate Program that has been offered by the Institute for Ethics in the past.

The Ethics Certificate Program was offered on a semester basis (spring and fall) in two modules. **Module I** had two full day sessions held on the Saturday at the beginning and end of the section and there were eight weekly sessions held in the evening for two hours each session. **Module II** had one full day session at the end of the section and five weekly evening sessions also for two hours each. The first module began with a speaker educating participants about ethics in general, the difference between ethics and morals, and the role of the various professional ethics. Topics covered in each certificate program were partially guided by the participant's interests and professional disciplines. Some of the topics included: end of life, the law, culture, spirituality, environmental ethics, and abortion. Joan Gibson, Ph.D., was a regular presenter on the topic of Values Based Decision Making. Continuing education credit was applied for and provided for the respective professional disciplines.

Dr. Simpson also shared that the Institute had held a seminar entitled SERV – "Seminar in Ethics and Values" for the greater Albuquerque community in the past. Additionally, the Institute collaborated with the UNM School of Law on a two credit hour course titled "Analysis of Professionalism", where the students were educated about ethical models and then challenged with working through several ethical dilemmas as a team.

It was commented that the history of teaching ethics has occurred in a more unintentional way rather than intentional and that may not be the best route to follow. Additionally, it was commented that having an opportunity to expose HSC students to the respective codes of ethics, identify their similarities and the impact of learning about interdisciplinary roles would benefit overall patient treatment and quality of care.

The work group was very grateful for the attendance and insight from Dr. Bolton and Dr. Simpson.

The next steps could include how to scale up the Ethics Certificate program for a larger interprofessional group of students. Whether that is large, interactive lectures or small group work remains to be seen.

The IPE Ethics & Professionalism work group includes: Catherine Combs (SOM), Denai Forrest (CON), Donald Godwin (COP), Elizabeth Greer (SOM), Mary Jacintha (SOM) and Amy Robinson (SOM). Interested colleagues are welcome and should contact Cathy Combs for meeting information.

Stories from the Nexus:

Care by Design: Integrating Practice and Education in Utah

This "Story from the Nexus" was recommended by Paul Grundy, MD, MPH, FACOEM, FACPM. Dr. Grundy is founding president of the Patient Centered Primary Care Collaborative and director, IBM Global Healthcare Transformation. Dr. Grundy is also a member of the national advisory council for National Center for Interprofessional Practice and Education.

The beginning

In 2003, when Michael Magill, MD and his colleagues set out to enhance the primary care practice for University of Utah community clinics, they faced a "chicken and egg" question of which comes first – **redesign the delivery system** *or* **create and train interprofessional health care teams**. Clearly, both are important, but where should they start? How could they improve both patient health and satisfaction? How could education be most effectively integrated with practice? The answers to these and other questions resulted in Care by Design, the University of Utah's adaptation of principles of the Patient Centered Medical Home (PCMH).

According to Dr. Magill, professor and chair of family and preventive medicine, "We started with the delivery system redesign and used that as a platform for education, training people in a redesigned practice. We started our pathway a decade ago and we've embedded education into the redesigned practices over time." Magill served for ten years as executive medical director of the University of Utah Hospitals and Clinics/Community Physician Group.

The model

Care by Design is the care delivery system for the 10 multidisciplinary University of Utah Community Clinics that serve approximately 120,000 patients and provide 350,000 visits annually. This nationally recognized primary care system is one of the first in the nation to combine acute, chronic and preventive care into a comprehensive system for treating patients.

Care By Design consists of three components--the care team model, appropriate access and planned care. These allow community clinic providers to plan each patient's care from before they enter the clinic through post-appointment follow-ups.

At the core of the model is collaboration between medical assistants (MAs) and physicians to optimize the patient experience. MAs assume a central role in the visit -- greeting the patient, taking the medical history, drawing blood and documenting the physician's exam. This reduces wait time and allows doctors to spend more time with their patients.

The access component balances the needs of acute patients who want same-day appointments with those who have chronic illnesses and should be regularly seen over time. Planned care uses evidence-based tools and electronic medical records to make each patient's visit more productive.

Dr. Magill comments, "I have a colleague who was seen as a patient in one of our practices. He said, 'That was as perfect as visit as could be imagined.' The microsystem for us is the expanded role of the medical assistant. The core team is the physician and medical assistant. The next layer includes other members of the team -- clinical pharmacists, psychologists, nurses, care managers. The experience of the patient should be a perfect visit with the right people to address their issues. We do that."

Integrating education and practice

An early educational experience in Care by Design developed by chance. "I was presenting to a group of first-year medical students years ago. Several of them said, 'We have to do something in the summer. Can we come and be medical assistants?' We hired four medical students in a new job category. They loved it and did a terrific job. That became the pilot for a new experience in our redesigned curriculum."

These days, medical students spend time in the clinics beginning in January of their first year. Every two weeks they serve as medical assistants in the medical home. They take the patients to the exam room, scribe the history in the template and stay in the room while the physician does the physical. Dr. Magill explains, "They are right there at the front line in a concrete role supported by an information system to guide them. They don't need to know much. This clinical exposure gives them an opportunity to watch, then grow into the physician role with patients. They are part of a team from day one."

Family practice residents work in clinic teams with medical assistants, clinical pharmacists and others. "We embed our residents in multiple setting with interprofessional teams as a matter of course. They just think that's normal. For example, we have a geriatric clinic led by a nutrition faculty member who is also a gerontologist. The team includes a resident physician, geriatrician and care manager. Another geriatric clinic is in an assisted living facility. A key leader of the multidisciplinary team there is one of our physician assistant faculty members."

Building and sustaining teams

A significant lesson learned by the University of Utah team was the challenge of developing a significant level of "team-ness" -- not just different professionals working in the same space, but truly working as a single, coordinated group.

Dr. Magill talks about the importance of taking time to establish a team, "You cannot possibly overestimate how much ongoing education, training and practice in team building you have to do to maintain a high functioning team. It takes much more attention than people imagine."

"When we launched our first site, we had a fortunate disaster. We had a month delay in our ability to open the practice. Since we'd already hired everybody, we used that time to run simulations with our physicians, medical assistants and others. We wanted to see how the teams would actually function. It

was terrific. We need to pay as much attention to how they function just as pilots do when they are learning to fly airplanes in simulators."

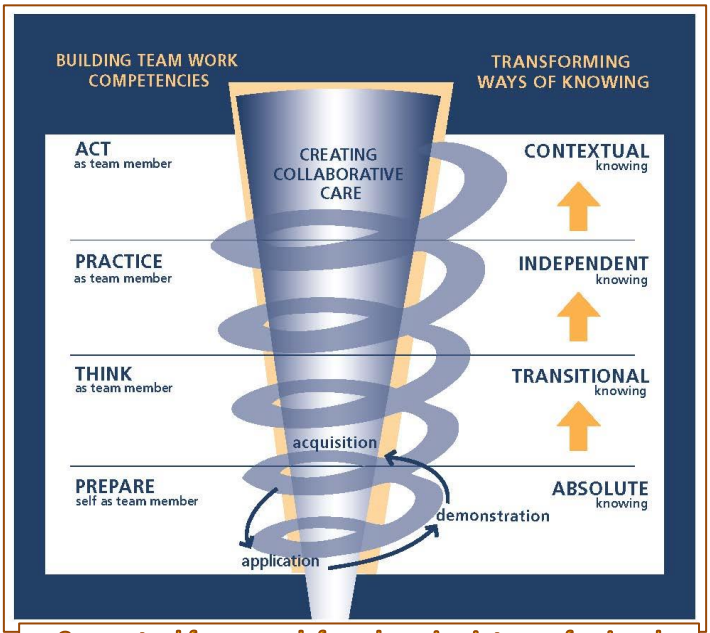
He continues, "We have a robust quality improvement program for our two family medicine faculty/resident practices, anchored in a meeting once a month for a half day. We actually close the clinics. In one room, we have all of our physicians and faculty, residents and staff – PAs, RNs, medical assistants, care managers. They start together with common training to answer questions such as, Why do we do what we do? Then they split up into various aggregations of teams, first by clinic, then by function. They address issues like, 'How are we doing in our flu shot protocol?' Every resident is required to complete a year-long quality improvement project leading a team. This gives them real experience leading a team."

The story's punch line?

Dr. Magill concludes, "I firmly believe interprofessional teams are essential to transform health care. To transform the clinicians, however, you've got to have the practice first, then have the learners see the practice and participate in it. We can't send them into a broken world and expect them to do it themselves. I'm proud of our practice and building the curriculum on what is already functioning. This is a journey, we're not done."

For more information about University of Utah's Care by Design, contact Dr. Michael Magill at michael.magill@hsc.utah.edu or 801-581-4074.

Article at: https://nexusipe.org/news/stories-nexus-care-design-integrating-practice-and-education-utah



Conceptual framework for advancing interprofessional education—Medical University of South Carolina
(IPEC Report of an Expert Panel, May 2011)

Fundraiser $'s Result in Meds & Supplies for the Homeless

UNM HSC Student Run Clinic for the Homeless (SRCH)

Thomas Schelby

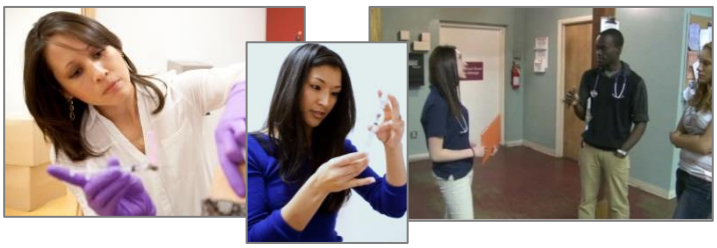
Earlier this year, the UNM HSC Student Run Clinic for the Homeless (or SRCH) spearheaded 2 separate fundraisers, the first was sponsored by **Garcia's Kitchen** here on the HSC Plaza last spring, and the second was sponsored by **B2B Bistronomy** in their Albuquerque bistro early this summer. These two fundraising events raised a total of **$680.33** and will provide much-needed over-the-counter medications and medical supplies to members of our community who may not, normally, have access to health care.

SRCH is completely supported through fundraising and past grant support, with more fundraisers being planned for Fall 2014. These projects were supported and assisted by almost every member of SRCH.

The Student Run Clinic for the Homeless is a non-profit, interdisciplinary student run organization comprised of volunteer medical, PA, PT/OT, EMS, nursing and pharmacy students, guided by dedicated UNM physicians/residents, and faculty from the OT/PT programs, College of Nursing and College of Pharmacy.

Together, they serve a diverse group of homeless people in the Albuquerque area through Health Care for the Homeless. Our clinics include: **Good Shepherd**—a residential drug/alcohol treatment facility; **Albuquerque Opportunity Center (AOC)**—an emergency shelter and services center for homeless men; and the **Barrett House**—a housing and supportive service for homeless women and children.

The mission is to offer underserved patients a positive health care experience by managing acute problems and providing access to continuing care through referrals to appropriate community resources. Additionally, it creates an environment in which students, preceptors, and patients may learn from and teach one another. It is a great opportunity for students to practice patient history-taking and physical exam skills, and also gain expertise in serving vulnerable populations.



Date: Monday, August 18, 10:00-11:00 am MT

Assessment and Evaluation in IPE: Collaboration and Satisfaction About Care Decisions (CSACD)

Location: Assessment & Learning Studio, HSLIC *(lower level of HSLIC, enter **exterior door only** between Fitz Hall [formerly BMSB] and HSLIC)*

The IPE Team invites you to join us to view this National Center webinar as a group (space is limited to the first 20 attendees; email IPE-Office to save a seat. Or, see below to register individually).

Judith Gedney Baggs, PhD, RN, FAAN
Distinguished Professor,
Oregon Health & Science University
School of Nursing

The presentation will describe the development, testing, and use of the Collaboration and Satisfaction about Care Decisions (CSACD) instrument. Since its initial development, this tool has been used for assessment by patients, patient families, and care providers in acute care and primary care settings. Join us for a discussion of this innovative tool, how it relates to the IPEC competencies, and how it might be adapted for use in interprofessional education and practice.

Learning Objectives

- Be able to articulate one psychometric process for instrument development.
- Be familiar with one definition of collaboration and its critical attributes.
- Know how to access a reliable and valid instrument for measurement of collaboration and satisfaction of health care providers related to decision making in various settings.

This session is the third in an ongoing webinar series on assessment in interprofessional education and collaborative practice. View the first session, *Making Sense of Assessment in Interprofessional Education and Collaborative Practice* and second session, *Global Leadership Consultancies in Interprofessional Practice, Education and Research: Assessment of Teamwork* on the National Center's Resource Exchange.

To Register individually for this session:
https://nexusipe.wufoo.com/forms/k1vqmea30ta6q60/

Paramedics and EMTS: *From Prehospital to In-Hospital—The Continuum for Time-Sensitive Care*

The recent **WIHI** program on July 24th featured several experts speaking on the evolution of emergency medical services (EMS) as they are becoming part of fully integrated health care systems, and paramedics are being trained and equipped to initiate even more life-saving and beneficial treatments in the field. The very use of the term "prehospital" reflects new strategies and capabilities to respond more effectively to patients suffering heart attacks, strokes, and traumatic injuries. Here are just a couple of snippets for you:

One of the speakers, **Jonathan R. Studnek, PhD, NRP,** Quality Improvement Manager, Mecklenburg EMS Agency (North Carolina) believes that there are 2 key pieces to their success in EMS in the improvement and healthcare realms; one is understanding the series of linked processes from out-of-hospital to in-hospital systems, and then using improvement methodologies to improve patient results. After deconstructing their system to understand the process steps—including time factors for each and advance communications with the hospital—they found there becomes a seamless level of care as the patient goes on to the appropriate care unit. "If you understand these pieces and how they fit together, and start erasing that wall between prehospital and in-hospital care, you start seeing some really good improvement," Studnek stated.

By using small scale testing, like a focused approach to cardiac arrest, understanding how to track and control quality chest compressions, Studnek reported that last fiscal year, they saw a shift in their performance and had an increased cardiac arrest survival rate that topped out at about 51% (from 30-33% previously). "We credit a lot of that to being able to systematically implement the state of science in cardiac arrest using improvement methodology. Those 2 pieces, understanding your system and how you're linked together as healthcare providers and then using improvement methodology can really help move EMS forward as a profession and as healthcare providers," Studnek said.

Another speaker, **Kevin Rooney, MBChB, FRCA, FFICM,** Consultant in Anaesthesia and Intensive Care Medicine; Professor of Care Improvement, University of the West of Scotland, highlighted that their patients, at risk for septic shock, are being targeted for early recognition and initiation of treatment by EMS staff. He also shared their National Early Warning Score (*NEWS*), a chart designed to improve detection and treatment of severe sepsis and septic shock in patients (available in the slide presentation).

The audio recording and slide presentation are available at: http://www.ihi.org/resources/Pages/AudioandVideo/WIHIContinuumofTimeSensitiveCare.aspx

Proposals due: Tuesday, Sept. 30th
Event date: Monday, October 27th

You are invited to submit a poster that showcases your teaching and/or curriculum projects in the area of interprofessional education (IPE).

Instructions for Submission

Each HSC faculty member is invited to submit one poster proposal for review and acceptance for the poster session. Your one-page, single-spaced proposal must include the following:

- *Title of poster presentation*
- *Names, titles, and affiliations of presenters*
- *Departments/Colleges/Schools involved in this interprofessional education endeavor*
- *Statement of which of the following Interprofessional Education Collaborative core-competency domains are addressed in your poster* (further information available at: https://ipecollaborative.org/uploads/IPEC-Core-Competencies.pdf). Note: Your poster must include the "Relevant IPEC Competency Domain(s)" in a text block below your title and authors list.

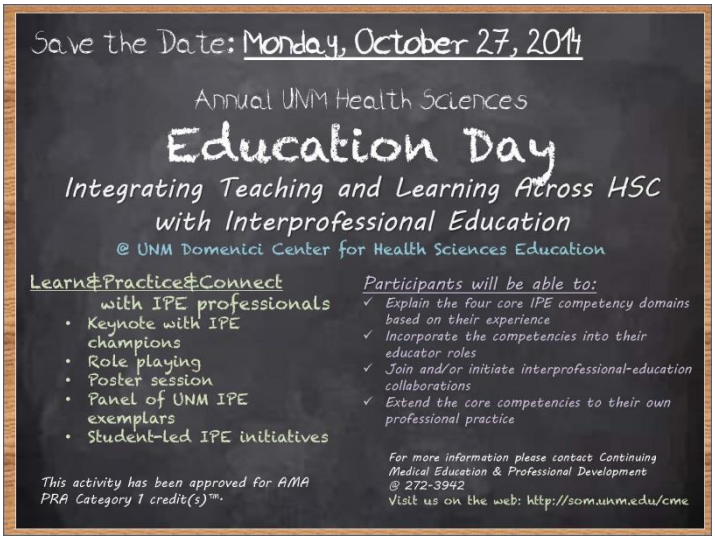
DOMAINS

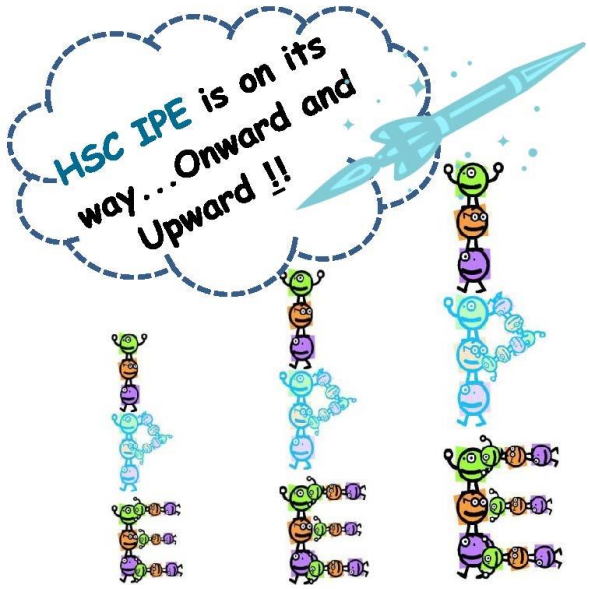
1. **Values/Ethics for Interprofessional Practice**: Work with individuals of other professions to maintain a climate of mutual respect and shared values.
2. **Roles/Responsibilities**: Use the knowledge of one's own role and those of other professions to appropriately assess and address the healthcare needs of the patients and populations served.
3. **Interprofessional Communication**: Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to the maintenance of health and the treatment of disease.
4. **Teams and Teamwork**: Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient-/population-centered care that is safe, timely, efficient, effective, and equitable.

- *A brief description of your teaching activity and/or curriculum project that will be the focus of your poster.* What did you do? How does your effort provide useful knowledge for other HSC faculty wishing to include interprofessional education in their curriculum? What assessments of student learning and/or attitudes toward your innovation are available to include in your poster presentation?

Your one-page proposal should be submitted as an email attachment to Dr. Gary Smith, Director, Office for Medical Educator Development (gsmith@salud.unm.edu) by **September 30, 2014**.

You will be responsible to deliver and mount your poster between 8:30 AM and 10:00 AM on October 27 in the Domenici Auditorium lobby. Your poster will be part of an interactive session between 3:00 and 4:30 PM and presenters need to be available to discuss their poster with attendees at that time.





By David M.Williams, Ph.D., Consultant & Researcher
Summer 2014 | Ambulancetoday

*In 1996, the National Highway Traffic Administration's EMS division, the Federal regulatory body over ambulance service in the United States, published the **Emergency Medical Services Agenda for the Future**.*

In the introduction, the document profiles a cardiac patient calling 911, complaining of chest pain, resulting in prehospital intervention and emergency care. The ambulance service care does not end there and the ambulance service supports the patient upon discharge with follow up care, medications management, and following through with their discharge care plans.

Nearly 20 years ago, the steering group of industry leaders and stakeholders were predicting an expanded scope for ambulance service that is now beginning to be realized.

It's difficult to identify when the concept of community paramedicine emerged. Peer-reviewed papers only began documenting results in the 2000s. Examples of paramedics practicing in ways in addition to emergency response and transport can be found throughout the profession's history. Established in 1992, the Red River Project of the TAOS Health Outreach Program in Red River, New Mexico was one of the first examples of paramedics acting in a primary care role in a rural setting. The new attention to post discharge care and high utilizers appears more recent. It took 20 years or more for these concepts and ideas to reach the critical mass we see today.

Scope of Expanded Services

The scope of community paramedicine practice varies and may take different forms in urban and rural environments. The following is a description of some of the varied services community paramedics are providing:

- **Primary care extension:**
  Paramedics work directly with a population of patients to support them in understanding and managing their care in areas where access to primary care may be limited or nonexistent. This could include assessment, health screening, medications management, and basic human needs support.
- **Chronic Mental Health:**
  Paramedics partner with mental health colleagues to respond to, assess and manage the patients to the most appropriate care to meet their needs and frequently outside of the emergency medical system. While the call may initiate as an ambulance activation, patients are assessed and navigated to care sources other than an accident and emergency department.
- **High Utilizers:**
  Paramedics working directly with patients that are super users of ambulance service. Super users include patients accessing ambulance service 15 times in a 90-day period. Through direct case management and connection with available resources and services, utilization is reduced.
- **Post Discharge Care:**
  Reducing readmission has been a key focus of health systems in the United States. Paramedics are deployed and available to provide discharge instruction coaching, home assessment, and follow up care that may reduce the potential of costly readmission.
- **Facilitating Alternative Destinations:**
  Ambulance service payment has been limited to A&E transport and no payments exists for no transport. The potential savings estimated from allowing flexibility for ambulance services to navigate low acuity patients to other care sources was estimated to result in US $283-560 million per year in savings to the federal Medicare program alone.


MedStar Mobile Healthcare, Ft. Worth, Texas

These are just a sampling of current services offered by community paramedic programs. There are many more pilot examples including immunizations, 24-hour observations, physician on call, hospice support and others. In many instances, paramedics are filling a gap in the healthcare system or providing a unique availability 24-hours a day that others cannot.

Case for Educational Standards

There is little disagreement that providers practicing in these expanded service lines should be adequately trained to support their new work. Where there is not yet consensus is what that curriculum should include, whether there can be a single curriculum, if there is a need for an added credential and who should be responsible.

The diversity of communities engaging in community paramedicine programs and variation in services being offered makes developing a single training program challenging. Add the evolving scope and many organizations are developing and adding training "just-in-time" as they refine their theory of where paramedics can help and what partners are asking them to serve.

Eagle County Paramedic Services, Edwards, Colorado

Several leaders have collaborated to create a Community Paramedic Curriculum. They aimed to create a foundational body of knowledge, delivered at academic institutions, and support a more professional designation. Creating a standard curriculum is ambitious and with positive intent but there is concern it is too early to determine the ideal training when a well-articulated scope of practice and predicted outcome measures are not present. Also, the initial developers were based in pilot programs focused on extended primary care services while urban pilot programs began with emphasis on high utilizers and psych-social patients.

Regulators are also watching closely. Paramedic scope of practice is regulated at the State level and changing of the scope of practice falls under the authority of state EMS offices. This may not be an issue if curriculum does not change practice, but rather supplements it similar to programs like Advanced Cardiac Life Support or Prehospital Trauma Life Support.

One opportunity the curriculum does provide the ambulance sector is a place to start, test, and evolve as pilot programs better appreciate the needs they can serve, the processes necessary to sustainably deploy them, and the outcomes they hope to influence.

MedStar Mobile Healthcare, Ft. Worth, Texas

Summary

There is clear need for low acuity and preventative care in the community. The use of community paramedics may be an economical and sustainable approach. The existing evidence to evaluate and understand outcomes is light and there is no defined change theory or measurement strategy in place. It's not clear how ambulance service will play a role as healthcare reform evolves to focus on improving quality and patient experience while reducing costs of populations. Patients will hopefully be the primary beneficiaries of whatever the resulting model becomes. The current, episodic, emergency response service design has to change.

For complete article, see page 23: http://www.ambulancetoday.co.uk/Summer2014/

Save the Date!!

IPE Faculty Development Workshop

Date: Wednesday, November 12th

Time: 9:00-11:30 am

Location: Domenici West Room 3010

Designing an IPE Experience

By the end of this workshop you will be able to:

1. Describe and apply Fink's taxonomy as a framework for developing an IPE curricular initiative
2. Apply a model to evaluate the quality of an IPE activity
3. Collaborate with a group to present an IPE initiative
4. Discuss ways to effectively implement your curricular initiative

Watch for Registration info to come! Contact: IPE-Office@salud.unm.edu

UNM CON Adds Geriatric Gynecological Content to VCU/ IPE Geriatric Online Program

Kristen Ostrem, Shelley Modell

The partnership between UNM and Virginia Commonwealth University (VCU) continues to move forward in ways that have resulted in exciting and unexpected interprofessional education learning opportunities.

Kristen Ostrem, CFNP, CNM, MSN, nurse-midwifery concentration coordinator, and nurse-midwifery faculty colleagues from the UNM College of Nursing, have taken one of four units of the VCU online course and are excited about adding geriatric gynecological content.

Barbara Overman PhD, CNM, RN and **Felina Ortiz, MSN, CNM** are helping to develop the case so that it can be used *virtually, in person with a standardized patient, or as an OSCE* (Objective Structured Clinical Examination). This unit of the case will be tested on August 18, 2014, during which time graduate nursing students will interact with a standardized patient acting as "Mattie Johnson."

"Mattie is the virtual patient created by VCU. We are using Mattie's information to create a gyn component of the case. Our goal is to continue development of further issues for the different units as Mattie's circumstances change over time and she becomes less and less independent," explained Ostrem.

Mattie will be played by a volunteer actor on August 18th for the pilot case, bringing Mattie out of the virtual world and into simulation.

Ostrem added, "We are developing a follow-up visit for gyn complaints. The student will need to do a full review of the care Mattie has received and make recommendations for treatment of her gyn symptoms." The case will involve unit one where Mattie is still fairly independent and dealing with multiple health issues.

The student will also note that Mattie has other primary care needs that require collaboration with other providers, such as social work, medicine and pharmacy. The expectation is that the nurse-midwifery student will recognize these issues and coordinate the care connections that Mattie needs.

"One of the learning objectives is for nurse-midwifery students to learn about primary care for the older woman. Nurse-Midwives are primary care providers as defined by Medicare, Medicaid and other private insurance carriers. As our clients age, we want our curriculum to reflect the care components that change along with our clients. This allows for continuity of care, which is associated with improved health outcomes," stated Ostrem.

Following their interaction with the patient, the student will be able to meet with a medical and pharmacy student to discuss patient findings and develop a collaborative plan of care.

The UNM/VCU collaboration began in April with a small pilot with students from medicine, pharmacy, nursing and social work to test the technical aspects of accessing the VCU system and evaluating the course content and on-line experience. Then, on May 1, 2014, Dr. Peter Boling, VCU's Chief of Geriatric Medicine, visited UNM to conduct a simulation of the course with HSC deans and faculty. A larger pilot of the course, using all four units, is planned for fall 2014. The full course extends over a period of six weeks, during which time interprofessional teams of 7-8 members learn about the care of geriatric patients while also improving skills at collaborative practice.

Funding for the UNM/VCU collaboration is provided through a grant from the Donald W. Reynolds Foundation. The Reynolds Foundation funds select institutions committed to expanding both geriatric medicine and interprofessional education. The University of New Mexico has been a recipient of two Reynolds Foundation cycles of funding totalling $2million.

If you would like to learn more about the UNM/VCU Partnership, contact Shelley Modell at SModell@salud.unm.edu

Upcoming VCU Online IPE Complex- Case-Based Course

Are you grappling with how to integrate

IPE

into your curriculum?

Is scheduling across disciplines preventing IPE success?

We invite you to explore the possibility of offering an On-Line Interprofessional Complex-Case-Based Course.

It's as easy as

1. Participate in a Live Demo of the Course (at a time & place that works for you)

2. Join the next pilot of the course (5-10 students needed from Medicine, Pharmacy, Nursing, Social Work, PA, Pt and OT)

3. Participate in a Proctor Training for the course, with Peter Boling, MD (Chief of Geriatrics at Virginia Commonwealth University and creator of the course)

Please contact me to discuss any of these offerings.

Shelley Modell, Reynolds Program Coordinator
Internal Medicine/Geriatrics
505/925-0322 SModell@salud.unm.edu

To schedule the next pilot, the group is currently working with the respective colleges to sync schedules. The proctor training will be via video conference with Dr. Peter Boling from VCU. Once a cohort of students are signed up, video conference training for the proctors will be scheduled on a relatively short turn-around time. Stay tuned! Contact: Shelley Modell for current information.

THE UNIVERSITY OF NEW MEXICO ◆ HEALTH SCIENCES CENTER
SCHOOL OF MEDICINE

Senior Mentor Program

Pairing active seniors with students to enhance provider-patient communication

Lloryn Swan

The Senior Mentor Program will include students from School of Medicine, Physician Assistant program, Occupational Therapy program, and Physical Therapy program will join with active seniors, 70 and older, from the community.

What's Involved?

The program includes an orientation meeting between senior mentor and students and a ***Meet Your Partner*** event. Requirements over the academic year are: Three (3) one-on-one meetings; several optional group events; and a brief written evaluation on completion. The total student commitment is 15-20 hours during the academic year.

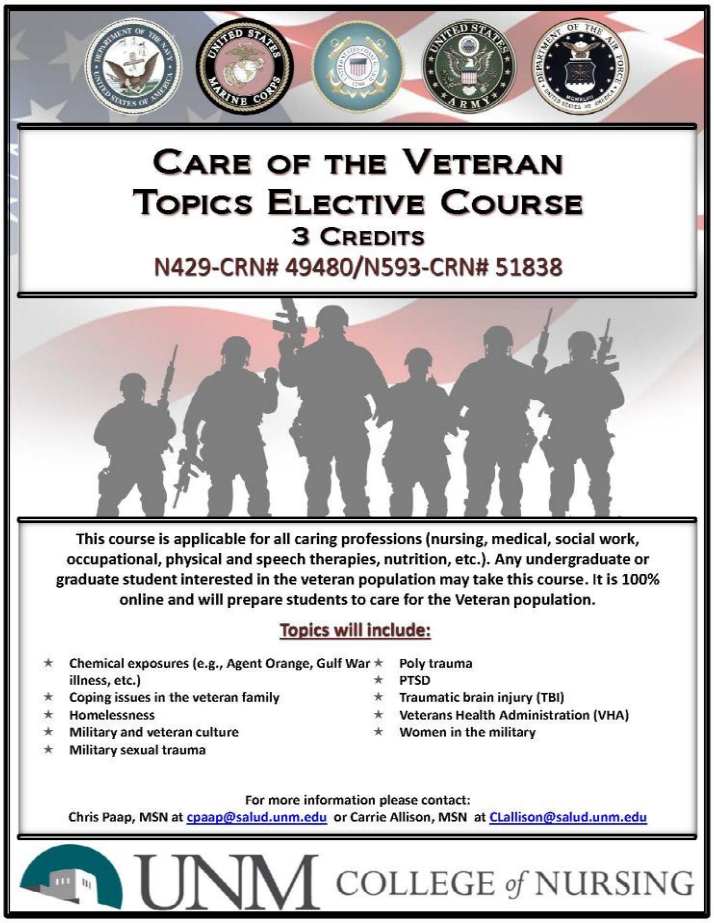
Why Participate?

The Senior Mentor program is an opportunity to practice your communication skills, to learn what seniors need from their medical providers, and to meet amazing seniors who have wisdom and life experience to share.

Email: Lloryn Swan, Program Director, or call 272-4837.

Recruiting for Senior Mentor Program

Lloryn Swan, Program Director for the Senior Mentor Program—on July 24, 2014 at the Student Organization Fair—busy recruiting new students.



AMERICAN JOURNAL of MEDICAL QUALITY

AJMQ Calls for Student Abstracts on Improvement Project or IPE Collaboration Experience

Would you like to publish your improvement project or experience working in an interdisciplinary team? The *American Journal of Medical Quality* (AJMQ) is calling upon health professions students to submit abstracts for publication in its "Quality Training to Improve Performance (Q-TIP)" column. As a part of the journal's effort to share student work on performance improvement, AJMQ will select eight abstracts for full article submissions and up to six articles will be published in AJMQ issues in 2015.

Abstracts of no more than 150 words, written by health professions students, describing improvement work and interdisciplinary collaborations should be sent by **August 20, 2014** to the faculty advisor, James Pelegano, MD, MS, (james.pelegano@jefferson.edu). Questions regarding "Q-TIP" may also be directed to Dr. Pelegano.

UCSF University of California San Francisco

Collaboration and Communication in Healthcare: Interprofessional Practice

Interprofessional collaborative practice is key to safe, high quality, accessible, patient-centered care. This course aims to introduce health professions learners to the fundamental principles and skills for effective interprofessional collaborative practice.

About the Course

Interprofessional collaborative practice is essential to the provision of safe, high quality patient-centered care. This course will introduce health professions learners to the concept of interprofessional collaborative practice and the evidence base that supports its effectiveness. In order for learners to better understand the professionals with whom they will collaborate, specific modules will focus on the roles of various healthcare professionals, their scope of practice, and settings in which they work. Additional modules will focus on communication strategies and tools for effective interprofessional collaborative practice and learners will practice to gain competence in interprofessional communication, conflict management and negotiation. Finally, the course will introduce the concepts of leadership and membership and explore leadership and membership strategies to promote effective interprofessional teamwork.

Course Syllabus

Week 1 - What is it all about? Introducing core interprofessional concepts

1. Define interprofessional education (IPE) and interprofessional collaborative practice.
2. Discuss the evidence regarding benefits of interprofessional collaborative practice, including the impact on quality and safety of patient care.
3. Compare and contrast different forms of interprofessional collaboration.
4. Discuss factors that influence interprofessional collaboration.
5. Describe key elements of effective interprofessional team-based care.
6. Identify barriers to interprofessional collaborative practice.

Week 2 - Who is on my team? Understanding roles, responsibilities and abilities of different professions

1. Describe the roles, responsibilities and abilities of various health care professions involved in collaborative work, including their training and scopes of practice.
2. Describe one's own professional role in relation to collaborating with other professionals.
3. Describe the process by which the scope of practice for a healthcare professional is determined.

4. Discuss and describe the role of patients, their families and community representatives as integral partners in the collaborative care delivery process.
5. Assess how different clinical settings might affect roles and responsibilities of health professionals.

Week 3 - How will our work get done? Understanding communication, accountability and task distribution.

1. List the benefits of collaborative practice to your work.
2. Describe the importance of communication for effective collaboration.
3. Name essential elements of effective communication.
4. Demonstrate use of strategies and tools that facilitate effective communication and collaboration.
5. Identify ways to distribute and follow-up on tasks among interprofessional health care providers.

Week 4 – How to tackle challenges: Conflict management and negotiation

1. Describe the sources of conflict in the healthcare setting.
2. Describe two main types of conflict and how they are interrelated as well as impact team functioning.
3. Compare and contrast different styles of managing conflict.
4. Describe one's own conflict management style.
5. Demonstrate a three-step approach to managing conflict.
6. Describe communication strategies helpful in the management of conflict.

Week 5 – How can we work together? Leadership and Membership

1. Define clinical leadership.
2. Discuss leadership functions that facilitate team-based health care.
3. Describe the concepts and importance of psychological safety and leader inclusiveness.
4. Analyze one's own strengths, areas for development, and leadership style.
5. Define team membership styles and their impact.
6. Demonstrate use of strategies and tools for effective healthcare team leadership and membership.

Course Format

Each of the five online modules will be two hours in length and will be comprised of a series of short (10-15 minute) lectures, supported with critical reading and interactive exercises which will assess student learning. The course will be offered over a five-week period.

Upcoming Session: Sept. 15 – Oct. 20, 2014

For additional information, or to sign up for the course, please visit https://www.coursera.org/#course/interprofessional