Preparing the Future Primary Care Workforce Together

Professionals Accelerating Clinical and Educational Redesign (PACER)

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*"The only time you should ever look back, is to see how far you've come."**

*Google image search: author unknown

Our Journey Started Right Here: The PCFDI

Selected Sites (out of 46 applications)

Advocate Lutheran General Hospital

University of Minnesota

University of Nebraska

Ohio State University

PCFDI was an important catalyst

2 yr Pilot, 4 institutions, 12 residencies (IM, FM, Peds), 36 faculty

**Carney et al, Acad Med 2015;90(8):1054-1060*

**Eiff et al, Acad Med 2016;91(9):1293-1304*

- Learning communities formed
- Despite their differences the teams all found a way to create cohesion and work collaboratively
- Speaking with one unified voice helped strengthen primary care

PCFDI → PACER
Interdisciplinary → Interprofessional

- Teamwork is needed in the PCMH.
- Many health professionals have never trained together in this model.
- We need IP practice opportunities for learners guided by patient needs.

  The practice is the curriculum.

- A learning community approach can accelerate change.

PACER

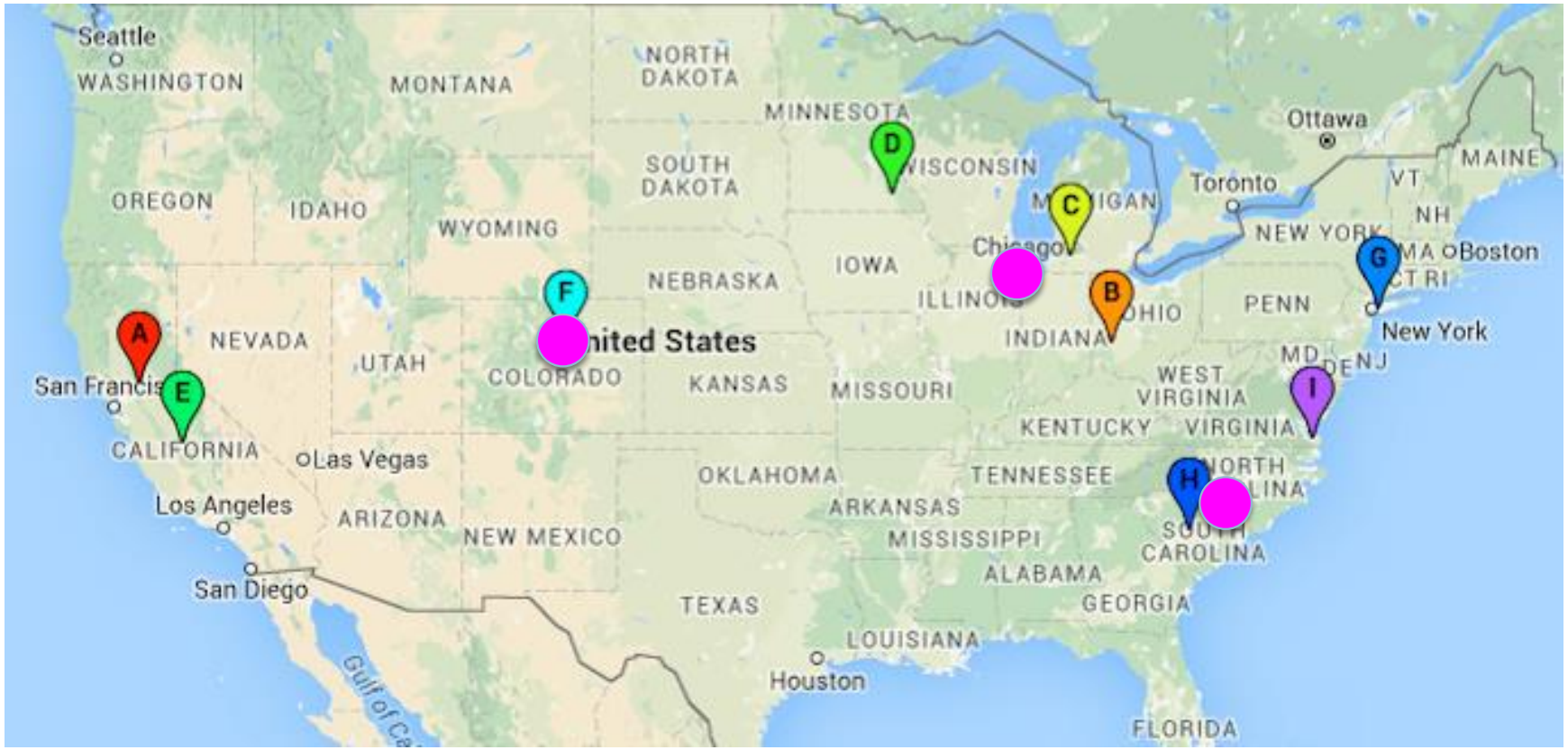
- 3 years, 9 institutions, 27 primary care residencies (FM, IM, Peds)
- 10 member IP faculty teams: medicine, nursing, pharmacy, physician assistant, behavioral health

Faculty Development Program

- to transform practices and educational programs
- to prepare trainees in high performing patient centered medical homes (PCMH)

9 PACER Teams

3 Regional Centers Planned



UC Davis
UCSF Fresno
University of Colorado
Mayo Clinic
Western Michigan University

Wright State University
Univ of So. Carolina/Palmetto Health
Eastern Virginia Medical School
Northwell Health

PACER Program

- April 2016: Training Session #1
- Aug-Dec 2016: Collaborative Site Visits
- Sep2017: Training Session #2
- Ongoing: Coaching
- Intervals: Topic-based Webinars

Unique Collaboration & Funding

Led by FM, IM and Peds certifying boards working in harmony

- Josiah Macy Jr. Foundation
- American Board of Family Medicine Foundation
- American Board of Internal Medicine
- American Board of Pediatrics Foundation
- Accreditation Council for Graduate Medical Education

What Have We Really Provided in PACER?

- We brought faculty teams together
- We coached them and empowered them
- We showed them models of how this could work
- We instilled hope that they could come together around their similarities and be strengthened by their differences

What Have They Done?

- They forged new relationships
- Teams unified around a shared vision
- They fostered peer and stakeholder support for their efforts
- They strengthened primary care at their institutions
- They moved IPE from the classroom to clinical settings

PACER Educational Redesign - examples

- IP Workshops (IP role identification, behavioral health, unconscious bias, PCMH concepts)
- Joint Grand Rounds
- Joint intern orientation to clinic- “scavenger hunt”
- Faculty Development (IP precepting, motivational interviewing)
- Interdisciplinary community health track for residents
- Joint MAT Curriculum

PACER Clinical Redesign - examples

- Adolescent to Adult transitions of care
- Improving team huddles and team meetings to include trainees and more professions
- Interprofessional Care Clinic – hot spotting team care to address SDH
- Unified PC voice to transform ambulatory policies, e.g. scope of practice for MAs
- IP forum to tackle EMR issues in primary care

Areas of commonality emerging from PACER teams

- Continuity of care
- Care coordination
- Managing transitions of care
- Patient engagement
- Team huddles
- Addressing SDH
- Clinician well-being
- Shared measures for evaluating change
- Learning more about professional training and roles for PAs, NPs, pharmacy, behavioral health

And it's Damn Hard Work….

- Primary care faculty are under siege and under-resourced
- You struggle to add this work on top of everything else you are doing
- You have stakeholders who are passively supportive but unwilling to provide real resources
- You get push-back and resistance from other faculty and staff
- Having multiple professions at the table is complex and challenging

Some Early Lessons

- Small changes can make a difference
  - Add learners from other professions to existing care coordination conferences
  - Add other learners to existing PCMH curriculum
  - Visit each other's clinics
  - Faculty from other professions overview their training requirements and curriculum
- Add learners even when the clinical model is "messy"

Key Insights

- Clinicians from different disciplines and professions who form a collaborative group build new working relationships; focus on shared goals rather than cultural differences; devise more robust and creative solutions to problems; and integrate ideas from their multiple perspectives into unified change efforts.
- Focusing on patient-centeredness with a shared understanding of what it means to be truly patient centered, i.e. moving beyond the checklist, is a common place for interdisciplinary and interprofessional collaboration and creates opportunities for skill building.
- Working across disciplines and professions requires patience because building trust and relationships can't be rushed (12-18 months of meeting regularly is typical).

Creating New Paths…

- Solving problems together
- Learning from others farther down the path
- Learning from others with different perspectives and different strengths
- Instilling hope that this work is possible and important