



Translating innovation: Exploring dissemination of a unique case conference



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ABSTRACT

Background/Purpose: As interprofessional education in clinical teaching settings continues to develop and workplace learning becomes more ubiquitous, early adopters will need to disseminate training innovations to diverse sites and programs. It is important for these sites to have a framework to understand and organize dissemination.

Methods: This study evaluated the dissemination process of a case conference across four geographically diverse sites. The dissemination process was evaluated using the RE-AIM framework with a multi-method evaluation that included trainee-level surveys, patient-level data, and semi-structured interviews with faculty members at all sites.

Results: The conference was disseminated effectively and with similar patient and trainee-level outcomes.

Conclusion: Suggestions for future dissemination projects include providing basic process and structural guidelines, allowing site-specific flexibility of implementation, providing a process for site-based evaluation (trainee, patient, and system level), and scheduling a check in call to discuss successes and troubleshooting challenges.

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The Institute of Medicine (IOM) has highlighted the need for health professions to work together as a team that delivers patient-centered care.¹ This statement has since been followed by the World Health Organizations' *Framework for Action on*

Interprofessional Education and Collaborative Practice that highlighted the opportunity for interprofessional education to enhance collaborative practice.² Building upon these statements, the expansion of coverage mandated by the Affordable Care Act has spurred interest in interprofessional education and team-based models of primary care.³ After the Department of Veterans Affairs (VA) transformed their primary care to a Patient Aligned Care Team (PACT) model, the VA Centers of Excellence in Primary Care Education (CoEPCE) were created to "foster

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transformation of clinical education by preparing graduates of health professions programs to work in and lead patient-centered interprofessional teams.”⁴ Five CoEPCE sites were selected in 2011.

An important component of effective interprofessional education is authentic team-based workplace learning experiences.⁵ Teams provide proactive, coordinated care for high-risk, high-utilization patients that can lead to improvements in cost and quality of care.⁶ In order to simultaneously realize these educational and clinical benefits, an interprofessional case conference for high-risk patients was developed at one of the CoEPCEs. This conference was locally successful at improving both trainee and patient outcomes,^{7–9} with patients’ that had been presented at PACT-ICU having significantly higher team-based visits without an increase in PCP visits.⁹ However, dissemination of health care innovations can be difficult for a variety of reasons,¹⁰ such as variations in site-specific barriers, rewards, and needs.¹¹ In response to the numerous challenges of dissemination and knowledge translation, there is increased attention to the theory and process of knowledge transfer.^{11–13}

In the present project we explore the dissemination of this case conference model to the four other CoEPCE sites and examine the facilitators and barriers to adoption and whether or not these sites achieve similar educational and clinical benefits.

To improve understanding of the interprofessional educational dissemination process, the RE-AIM framework was utilized. The RE-AIM (Reach, Effectiveness/Efficacy, Adoption, Implementation, Maintenance) framework was initially developed as a structure to evaluate the overall impact of health promotion interventions.¹⁴ This model has been used to evaluate the dissemination of numerous interventions in healthcare including diabetes self-management programs,¹⁵ chronic illness management programs,¹⁶ and an intervention to promote evidence-based practice implementation.¹⁷ A strength of this model is the inclusion of both individual (reach and efficacy/effectiveness) and system or program (adoption, implementation, and maintenance) level aspects of the dissemination process. For an innovation to be useful and generalizable across settings, many aspects of dissemination need to be considered and understood. The RE-AIM framework provides an appropriate structure to evaluate the dissemination of PACT-ICU from the foundation site to the four other geographically diverse sites.

The aim of this study was to evaluate the effectiveness of the dissemination of a locally successful interprofessional case conference to four diverse sites.

Methods

This study was reviewed and approved by the Institutional Review Boards at all five sites.

Intervention description

The interprofessional high-risk patient care conference, known as the PACT Interprofessional Care Update (PACT-ICU), began in January 2013 at one of the CoEPCEs. For the purpose of this paper, this site will be referred to as the foundation site. PACT-ICU at this site occurs twice a month for 1 h. This care conference has been described in detail previously.⁷ Briefly, learners from all five post-graduate training programs (nursing and advance practice nursing, pharmacy, psychology, and medicine) participate. Two primary care provider (PCP) trainees, NPs or physicians, present a patient from their panel that was selected using a two-step process. In step one, five patients from their panel are identified as the highest risk by the care assessment need (CAN) score, a VA-specific

estimate of the probability of death or hospitalization within the next 90 days,¹⁸ and the list is given to the PCP. In step two the PCP selects a patient to discuss from the CAN score list or, occasionally, selects an alternative patient to discuss due to other pressing needs. All trainees (presenters and discussants from other professions) perform a chart review using a structured worksheet. An inter-professional discussion is facilitated and at the conclusion of the discussion, the PCP creates a care plan that includes specific interventions along with the identified team members that will complete each task. This care plan is documented in the patient’s chart and providers with action items are assigned to cosign the note.

Dissemination process

Each dissemination site observed one or two 1-h presentations about PACT-ICU at national CoEPCE venues. In addition, each site had a 30-min phone call to answer any questions during their local development. Five core elements were explicitly exported to each of these dissemination sites:

- The expectation to include interprofessional trainees
- The structure of the case conference format
- The patient selection method (two step: CAN score then PCP choice)
- The structured chart review worksheet
- The standardized trainee survey (outcome measure)

Evaluation process

All four additional sites assessed the dissemination of the PACT-ICU conference and its impact on educational and patient care outcomes. In addition to collecting educational and patient outcomes, each site provided contact information for individuals who would be able to speak to the implementation of PACT-ICU at their site.

Quantitative assessment

To assess trainee educational outcomes, a previously developed self-report trainee survey was used.⁸ This survey consisted of a five-item Likert-type (1 = a few and 5 = most) post/retro-pre scale where trainees provided their self-assessment of their understanding of the different elements of patient care and team roles. This survey was designed to focus the evaluation on the most proximate effects of the PACT-ICU intervention due to other ongoing training on patient-centered care and interprofessional roles and responsibilities. The post/retro-pre design is superior when training reveals significant gaps and a “pre” test could have been unduly positive and also helps to exclude other confounding training effects of parallel educational programs.¹⁹

To assess patient outcomes, patient-level data was collected from the VA Corporate Data Warehouse (CDW) on all patients that met inclusion criteria for PACT-ICU. Propensity matched controls were selected from the group of individuals that were identified as high risk and had a similar chance of being chosen based on utilization modeling but were not presented at PACT-ICU. The patient with the highest propensity score presenting on the same day but not discussed at PACT-ICU was selected as the control. Utilization data was collected on PACT-ICU patients and controls for six months prior to PACT-ICU and six months following PACT-ICU. Patient utilization data included emergency department and episodic care visits, PCP visits, hospitalizations, and PACT team (non-PCP) visits. This same process was used at the foundation site and was previously presented by Weppner et al.⁹

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