Evidence-Guided Integration of Interprofessional Collaborative Practice into Nurse Managed Health Centers

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The Division of Nursing, Bureau of Health Workforce, has spearheaded a 3-year effort to increase the skills of nurses to lead interprofessional collaborative practice (IPCP) teams. Since 2012, the Nurse Education, Practice, Quality and Retention program has funded 53 sites engaged in this work. The purposes of this report are to describe the IPCP framework undergirding implementation at one such site, describe the evaluation components and approach, describe how health professions students are integrated into this model, and discuss implications of IPCP for future nurse-managed/nurse-led initiatives within an evolving health care environment. Core team members include a family nurse practitioner, physician, pharmacist, social worker, and community health advocate. The clinic is located within a public housing complex; the target population is largely uninsured or underinsured with a historically high rate of emergency department utilization. (Index words: Nurse-managed health centers; Interprofessional collaborative practice; Advanced practice nurse; APN) J Prof Nurs 31:340–350, 2015.

NURSE-MANAGED HEALTH centers or clinics (NMHCs) have been around since Lillian Wald opened the Henry Street Settlement House in the late 19th century (Henry Street Settlement). The scope of nurse-led services has certainly evolved since that time; however, the target population for these centers remains largely underserved, disenfranchised, and vulnerable (King, 2008; Van Zandt, Sloand, & Wilkins, 2008). According to the National Nursing Centers Consortium, there are more than 250 such clinics operating in all 50 states and the District of Columbia (Hansen-Turton, Bailey, Torres, & Ritter, 2010).

NMHCs are often affiliated with or attached to schools of nursing. Such arrangements greatly undergird the three-part mission of academic programs: clinical teaching, clinical practice for faculty as well as students, and research. The

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development of such sites proliferated in the 1980s and 1990s, when the Division of Nursing, Bureau of Health Professions (now Bureau of Health Workforce), Health Services Resources Administration awarded grant funding to spur their development (King, 2008). These grants were frequently multiyear, one-time awards, leaving the academic institution responsible for long-term sustainability. Not all NMHCs survived due to the operational expense accruing to the university's bottom line (Vonderheid, Pohl, Barkauskas, Gift, & Huges-Cromwick, 2003).

In the past 3 years, the Division of Nursing has shifted its funding focus to emphasize interprofessional collaborative practice (IPCP) within a nurse led or managed environment. The first cohort to be funded under this IPCP initiative began its work in September 2012. Two subsequent cohorts were awarded in 2013 and 2014. There are a total of 53 funded projects currently underway, 45 of which are affiliated with university schools of nursing. Sites are located in 25 states and the District of Columbia (Health Resources and Services Administration [HRSA]). The Clinic at Mercury Courts, developed by Vanderbilt School of Nursing, was funded in 2012 in the first cohort. This article describes its IPCP framework, evaluation approach, integration of health professions training, and implications for future nurse-managed/nurse-led initiatives within an evolving health care environment.

Background

The World Health Organization (WHO) defined IPCP as "when multiple health workers from different professional backgrounds work together with patients, families, carers [sic], and communities to deliver the highest quality of care", (2010, p. 7). The Interprofessional Education Collaborative Expert Panel (2011) defined interprofessional team-based care as care delivered by intentionally created, usually smaller work groups in health care, who are recognized by others as well as by themselves as having a collective identity and shared responsibility for a patient or group of patients.

The quest for IPCP is not new. In 1972, the Institute of Medicine (IOM) raised a number of provocative questions for discussion among all the health professions, challenging educators to move toward team-based education (IOM, 1972). Within that report, the IOM raised the issues of optimizing the workforce, cost-effective care delivery, and full-scope practice for all professions. These issues remain central to the current health care delivery system more than 40 years later.

More than a decade ago, The Pew Health Professions Commission called for major changes in health professions education in order to meet the demands of a new health care system (O'Neil & The Pew Health Professions Commission, 1998). From 2005 forward, frameworks emerged to capture the interconnectivity and interdependence between health professions education and health care practice (D'Amour & Oandasan, 2005; Frenk et al., 2010; WHO, 2010). In each of the emerging frameworks, the need for interprofessional education is seen as a means to accomplish improved patient and population outcomes (Interprofessional Education Collaborative Expert Panel, 2011).

In 2010, Vanderbilt University Schools of Nursing and Medicine partnered with three other health professional schools in Nashville, TN to launch an innovative interprofessional education pilot program. Selected students from nursing (prelicensure master of science in nursing students), medicine, social work, and pharmacy are admitted into the Vanderbilt Program in Interprofessional Learning (VPIL) for a continuity learning experience (Vanderbilt University School of Medicine). These interprofessional teams of students work and learn together in primarily ambulatory care environments within community and hospital-affiliated settings one half-day per week over a 2-year period. Overall program goals include (a) cultivate respectful professionals, (b) prepare a collaborative practice-ready workforce, (c) improve health care delivery systems, and (d) create self-directed lifelong learners. Student teams attend a week-long immersion prior to initiating study within their home professional schools. Over the course of 2 years, teams learn and work in their clinic placements one half-day per week. They meet in a classroom setting every month to learn skills, discuss cases, and share their experiences. The primary curricular topics include interprofessional plans of care, transitions of care/settings of care, team roles and responsibilities, advocacy, medication reconciliation, health coaching, quality improvement and patient safety, and patient-centered communication. There are opportunities for third- and fourth-year medical and pharmacy students to remain active with the program as senior mentors. See depiction of the VPIL program model in Figure 1.

At each clinical site, the student teams have a primary preceptor or preceptor team representing different professional perspectives, depending on the nature of the clinic. VPIL views all members of the clinic team as educators for students. Members of VPIL core faculty, representing all participating schools, rotate through the clinics to provide guidance to the students. They are onsite periodically when the students are present. They also provide interprofessional education coaching for the preceptors. The core faculty are also involved in classroom discussion, facilitation of simulation, and providing student feedback.

There have been many positive outcomes from this program; however, there are several major challenges to overcome:

1. Lack of interprofessional care role models. Few well-established and high-functioning IPCPs exist in the geographic area. Therefore, the lack of model practices makes it difficult to demonstrate in practice what the student learners are being taught and socialized to expect.
2. Limited clinical sites. Recruiting clinic sites willing to host a student team over a longitudinal period is difficult. Therefore, VPIL can only accommodate spots for approximately 10% of each professional class (N = 40 per year).