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June 2015

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HEALTH IS ALL WE DO

*Jefferson Center for InterProfessional Education*

# Interprofessional Education and Care Newsletter

## From the Editors:

As the spring semester comes to a close, we in the Jefferson Center for InterProfessional Education (JCIPE) reflect on the last year. In the Fall 2014 edition of the *Interprofessional Education and Care Newsletter*, we presented several innovative IPE projects from students, faculty and our colleagues overseas. The articles in this edition build on that progress, highlighting our efforts, redefined during a January 2015 Jefferson IPE retreat facilitated by Dr. Malcolm Cox, to more closely link IPE and clinical practice. To this end, the spring semester marked the conclusion of the first administration of our revised Jefferson Health Mentors Program (JHMP) Module 4. During the new module, students select one Learning Activity from a menu of 13 offerings, including clinical observations, simulations and collaborative practice opportunities. They then reflect on their participation in their selected Learning Activity in light of their experience with their Health Mentor. Two student essays, one discussing our new, student-led IPE Grand Rounds program detailed in the Fall 2014 edition of the newsletter and the other describing a TeamSTEPPS® training, demonstrate the impact of such clinically-focused activities and their application in students' training and lives.

Along with an emphasis on more clinically-relevant student programming, this year also saw a shift for JCIPE from primarily focusing on student training to working more with practicing clinicians. The Center conducted two pilot team training workshops based on TeamSTEPPS® principles for practitioners across the enterprise in addition to leading ongoing efforts to train the entire Department of Family and Community Medicine in the same area. The trainings include team building exercises, didactic presentations and simulation experiences to apply the learning.

Looking ahead to next academic year, JCIPE is proud to be partnering with various Colleges to further develop several advanced IPE electives. One of these, the "hotspotting" initiative, is described in detail by this year's participants and their faculty advisor in the body of the newsletter. The Center is also excited to be piloting an app of the Jefferson Teamwork Observation Guide (JTOG), an educational tool described in the Fall 2014 edition of the newsletter that was originally designed to teach students about the characteristics of effective teamwork, with both student and patient populations.

We look forward to seeing many of you and sharing ideas at the *Collaborating Across Borders V* conference in Roanoke, VA this fall. We wish you a productive, healthy and relaxing summer in the meantime!

**Elizabeth Speakman, EdD, RN, ANEF, FNAP**  
**Lauren Collins, MD**

**Christine Arenson, MD**  
**Shoshana Sicks, MEd**

### Spring 2015 Inside this Issue:

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# Development of a Cultural and Spiritual Toolbox: A High Impact Interprofessional Project

**Marian Nowak, DNP, MPH, RN, FCN**  
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## Abstract

Healthcare providers may not be prepared to incorporate cultural and spiritual aspects of patient care within their practice. The cultural and spiritual toolbox project will increase the opportunity for those working in a local three campus hospital system to deliver patient-centered care at the bedside by helping them recognize the nuances of various cultures and religions. An interprofessional team convened over a one year period to explore how these aspects of care could be met.

To this end, the team researched and developed a "Cultural and Spiritual Toolbox" which offers information in an online format. This project will be fully implemented in late 2015. It was designed and approved for use in a large non-religious affiliated hospital system with three campuses. The software program provides healthcare workers with a diverse cultural and spiritual reference to assist patient-centered bedside care. Faculty and students from Rutgers and the Rowan University School of Osteopathic Medicine collaboratively developed a comprehensive guide which addresses religions, cultures and practical strategies for healthcare providers.

This computer-based system was accepted by the ethics board on December 5, 2014. The toolbox modules were designed by an interprofessional team and reviewed by religious experts and ordained religious leaders from various faiths. It will be implemented once the computerized integration is completed. The program will be available to patients, families, caregivers, physicians, and staff members who seek assistance.

## The Issue

Cultural competency is considered critical to reducing health disparities and improving access to high quality healthcare. Care that is respectful of and responsive to the needs of diverse patients enables systems, agencies, and groups of professionals to function effectively and to understand the needs of others. Applying multiple aspects of health information allows providers to meet the patient on a common ground (NIH, 2015).

Prior to the development of this project, the healthcare workers in a large hospital system expressed concern regarding hospital resources available to guide healthcare professionals in providing culturally and spiritually competent care. Although there were religious leaders on call, immediate access to needed care information was not readily available. Anecdotal evidence indicates health care workers often have trouble accessing spiritual

leaders to provide care at the bedside. This project helps the unmet need to provide spiritual interventions in a timely manner by offering an immediate 24-hour resource for those caregivers. The content domains include identification of communications, customs, beliefs, values, and implications that are often specific to ethnic, racial, religious, geographic, or social groups (NIH, 2015).

## Background to the Project

The framework for this was first developed during an interprofessional workshop offered by the Thomas Jefferson University Center for InterProfessional Education (JCIPE). Under the advisement of Dr. Elizabeth Speakman, Co-Director of JCIPE, the phases of the project were first conceptualized and organized. In addition, Dr. Speakman has continued to guide a group of southern NJ professionals through the steps needed to bring this project from concept to implementation.

The premise that people are spiritual by virtue of their humanity speaks to the importance of honoring this aspect of the human dimension in a medical care setting. As bio-psycho- social-spiritual beings with cultural influences, it becomes critical that healthcare providers recognize this aspect of care while caring for patients. Widespread evidence shows that interest in spirituality is not just for church goers. Today many believe their spirituality helps promote healing (Koenig, King and Carson, 2012). Therefore, the importance of acknowledging the spiritual and cultural aspects of care is essential to restoring health. The contents of the toolbox module system are:

- Strategies to enhance cultural and spiritual care of patients.
- Resources for spiritual and cultural aspects of care.
- Information for further exploration of these topics.

## Project Development

The goal of the project is threefold. In the development phase, it provided the groundwork for students from varied cultural and religious backgrounds to discuss how spiritual and cultural factors affect care. It also gave students an opportunity to explore how this aspect of care leads to provisions of improved quality of care at the bedside. Team members learn from one another, collaborate and discuss the implementation of this project. It is viewed as a culturally sensitive intervention important in providing a high quality of patient care (AACN, 2011). Lastly, the project, once implemented, will cast a wide net of information to future health care providers.

# Development of a Cultural and Spiritual Toolbox: A High Impact Interprofessional Project (cont'd)

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The development of this project was accomplished in four phases:

- **Phase 1: Recruitments, orientation and planning.** In this phase the medical school and nursing school faculty solicited volunteers from the third year medical and nursing students. The student and faculty team met to discuss the project, projected timelines and roles, and conducted a brief review of related literature on this topic.
- **Phase 2. Content development, review and editing.** The team researched various aspects of care and developed the content to be offered in the program. The content was constructed to reflect current trends in cultural and spiritual focused literature. Thus each module contains information such as: overview of religion or culture, prayer practices, dietary needs, end of life issues, gender considerations, medication beliefs, and other special considerations. A consistent standard for each toolbox module was formulated.
- **Phase 3. Organizational-wide support.** In order to attract organizational-wide support, the hospital ethics committee was engaged. The goal was to seek support for the implementation of this project. This committee has representation from religious groups, providers, and hospital administration. All embraced the idea of making a commitment to provide excellent patient service by including the toolbox project within the hospital system. The faculty team spent time presenting information to the committee about the use and content presented in the toolbox resource. There was no funding for this project and the hospital system agreed to use current computer resources to use the modules developed by the interprofessional team.
- **Phase 4. Implementation and evaluation.** The implementation phase includes developing a format with the information technology department and posting the toolkit on the electronic hospital system in a quick and easy to use format. The program introduction to hospital staff will include administration of a pre- and post-survey. The evaluation instrument is adapted with permission from Georgetown University Mind, Body and Spirit National Center for Cultural Competencies.

## Discussion

The implementation of this project is projected to have a significant impact on the providers' awareness of specific cultural and spiritual implications of care. Although the modules are not intended to be all inclusive, the information

offers a comprehensive resource for health care professionals. The toolbox modules offer more involved information as a link which can be explored at a later time, or from home.

This toolbox offers nurses, doctors and social workers added information about various cultures and religions. If the health care providers are not aware of these implications, patient care can be compromised. For example, patients of Muslim origin may not want end of life care until their family has had an opportunity to offer prayers at the bedside. In this instance a provider can quickly access information about specifics of care.

Although it is impossible to predict how any one patient or family member may understand or apply religious guidelines, this toolbox gives the practitioner a starting point to have conversations and enhance the spiritual dimension of the human experience while in the hospital. The project highlights how a hospital system that is committed to meeting the needs of all people, regardless of cultural or religious backgrounds, can be equipped to do so.

## Conclusion

This toolbox project provides pertinent information to the healthcare team. It explores and enhances the interaction of health, faith and culture to improve the lives of individuals. The project is slated to begin in a local hospital system later in 2015. This project could not have been possible without the expertise and guidance of Dr. Elizabeth Speakman, Co-Director of JCIPE.

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# Interprofessional Student Hotspotting Project

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## **Background: IPE and Practice-based Learning**

It is well established that there is a need for Interprofessional Education (IPE) in the current landscape of health education<sup>1</sup> and students that participate in IPE enjoy these experiences and develop skills in interprofessional teamwork that prepare them for future team-based practice.<sup>2,3,4</sup> IPE, however, is not standardized. It ranges from programs that teach theoretical frameworks in a classroom setting to others that allow interprofessional teams of students to work together in a clinical setting.<sup>5,6</sup> The second form is referred to as practice-based learning (PrBL).<sup>3</sup> PrBL is now considered by experts as one of the most effective teaching methods.<sup>3,6</sup> Unfortunately, due to the lack of consistency of IPE programs and the lack of standardization in IPE research, there is inconsistency in data regarding the best IPE method.<sup>6,7</sup>

## **Camden Coalition and the Hotspotting Learning Collaborative**

An interprofessional team of Jefferson students participated in a six-month pilot learning collaborative, called "hotspotting," funded by a grant from the Camden Coalition of Healthcare Providers (CCHP) in conjunction with the Association of American Medical Colleges (AAMC) and Primary Care Progress (PCP). This project educated teams of students from multiple disciplines across the country about the gaps in the US healthcare system by focusing on the care of high-utilizing patients ("super-utilizers"). Super-utilizers have been defined as individuals who have at least six emergency room visits and/or at least three inpatient hospital stays in a two-year timeframe.<sup>8</sup> They typically face medical challenges as well as social barriers that keep them from getting the care they need in a very complex and fragmented healthcare environment.<sup>9</sup> Super-utilizers represent a small segment of the US population but account for the largest amount of healthcare costs. For example, the top 5% of highest utilizers account for nearly 50% of healthcare spending, and the top 1% account for more than 20% of overall healthcare costs.<sup>10</sup> As a result, CCHP targeted super-utilizers in the hotspotting initiative with the aim of better addressing patient needs and improving care quality while reducing costs. Focusing on patients with extreme patterns of high utilization can help reveal the shortcomings of healthcare and direct healthcare transformation.<sup>11</sup> The purpose of this article is to describe the Jefferson team's experience in this pilot IPE project.

## **Intervention**

A CCHP committee selected the Jefferson student team

along with nine other teams across the country out of an applicant pool of more than fifty universities. Jefferson's team consisted of six students from the following disciplines: medicine, occupational therapy, nursing/nurse practitioner, pharmacy, and couple and family therapy. Most students were in their final year of school and were nominated by faculty members in their respective disciplines. Patients who enrolled in the hotspotting program voluntarily signed waiver forms, approved by Jefferson's legal and public relations teams, which authorized the team's access to patients' medical records and gave permission to share and publicize patients' narratives. This project did not involve data collection for study purposes.

The project began with a webinar in May 2014 that explained the overall timeline and the topics to be covered in monthly webinars during the collaborative. The Jefferson team members met each other and their faculty advisors and began a team-building process. This included establishing rules for communication and documentation, and determining the team's goals. Member roles were created and assigned, including team contact person, secretary, faculty liaison, and community liaison. The students created a list of criteria to facilitate identification of appropriate patients through community and faculty contacts. However, meeting criteria was not required for enrollment. Such criteria included the following qualities: at least two hospitalizations in the past six months; a minimum of two chronic illnesses; more than one social concern (e.g., lacking support, poverty); age over eighteen; and openness/willingness to change. The CCHP recommended avoiding enrollment of patients with active substance abuse, active psychosis, severe mental health diagnoses, significant cognitive impairment or on hospice, as these issues may be less amenable to the students' interventions.

The recruitment process presented the students with their first challenge due to the lack of systems in place for identifying high-utilizing patients in the University's hospital in real time. Administrative data that included lists of high-utilizing patients were generally six months old and therefore, less useful for outreach in the hospital setting. Clinicians in the Department of Family and Community Medicine referred high-utilizing patients to the hotspotting team. Additionally, reaching out to residents in Family Medicine at Jefferson proved helpful, as they had an ongoing list of patients who were frequently admitted to their inpatient service. If one such patient was admitted to the hospital, the residents would explain the program to the patient, obtain patient permission to contact the hotspotting team, and email

# Interprofessional Student Hotspotting Project (cont'd)

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the team contact person. Two student representatives would then meet the patient for the first time while still in the hospital, discuss the program, and schedule a follow-up meeting either in the hospital or at home once the patient was discharged. The team would then compile de-identified utilization data and past medical history from Jefferson's EMR to create a patient profile, using password-protected computers and University email accounts. Experts in the field presented monthly webinars ("Getting Started with Hotspotting," "Engaging Patients outside the Hospital," "Motivational Interviewing," "Sharing Patient Stories"). Further support was available through monthly conference calls where the teams presented progress updates and challenges, while receiving feedback and advice from experts and peers.

Throughout the six-month intervention, the Jefferson team engaged five high-utilizing patients, and met with them in a variety of settings including the hospital, outpatient appointments, and patient homes. The students did not provide health care, but met with patients to listen to their stories and provide support. They helped patients identify their own goals and assisted them in navigating through medical and social systems to achieve those goals.

The Jefferson team utilized CCHP's model for transitioning and graduating patients. Transitioning consisted of communicating about the project with the patient's PCP so that newly established behaviors and protocols could be sustained. Graduation was an informal celebration of the patient's accomplishments. At the end of the intervention, the Jefferson team transitioned all five of their patients, and graduated one patient. The project culminated with a presentation to the Jefferson community and a full-day symposium with representatives from the ten student teams. The Jefferson student team has served in an advisory role to expand the program at TJUH, and is helping to design the recruitment methods for students and patients, the curriculum, and the timeline for the project.

## Conclusions

It is necessary in the current healthcare climate that students receive IPE in order to practice team-based care in the future.<sup>1,3</sup> While there is not a standard curriculum, it has been established that PrBL is one of the most effective methods to impart IPE competencies.<sup>3,6</sup> This pilot program is a prototype of IPE that applies the principles of PrBL.<sup>3</sup> CCHP is in the process of performing a qualitative analysis of students' experiences and changes in knowledge and attitudes in regards to interprofessional teamwork. Unfortunately, this program was not initiated with a standardized evaluation. While the students felt that it was a

novel and successful program, it is not yet clear whether and how it impacted their knowledge and skills, nor how it will impact future practice. Future evaluations should include a more robust pre-and post- and possibly longitudinal assessment to better evaluate the program's effect.

As the project concluded, the team identified the following lessons learned regarding implementation of their pilot project, which will impact future iterations. 1) The project must have a strong foundation of institutional buy-in and support from faculty members with experience in IPE. 2) It is beneficial to have protected time, access to claims data for high-utilizer patients, and institutional support to assist with patient referrals. 3) Team building and introductory course-work help to solidify the team and clarify roles and expectations. 4) There should be an online platform and standardized communication tools that facilitate team interaction with one another, their faculty advisors, and participants in other states. 5) It is preferable to recruit students in their final year of health professional school because they have experience working with patients in clinics and the hospital. They should be selected based on faculty recommendations and be both community-engaged and volunteer-oriented. 6) There should be broad representation from various fields. In conclusion, the students learned to work together with a variety of health professions, and use a patient-centered approach to care.

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Continued

# Interprofessional Student Hotspotting Project (Cont'd)

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## JCIPE 2015 AWARDEES

*Warmest congratulations to the recipients of the awards of  
excellence in interprofessional education and collaborative practice*

### **James B. Erdmann, PhD Award for Excellence in Interprofessional Education**

**Brooke Salzman, MD**

Department of Family & Community Medicine, Sidney Kimmel Medical College

**Kellie Smith, EdD, RN**

Jefferson College of Nursing

**John Duffy, RN, MSN, CCRN, CNRN – Honorable Mention**

Jefferson College of Nursing

**Alan Forstater, MD – Honorable Mention**

Department of Emergency Medicine, Sidney Kimmel Medical College

### **James B. Erdmann, PhD Award for Excellence in Interprofessional Collaborative Practice**

**Danielle Snyderman, MD**

Department of Family & Community Medicine, Sidney Kimmel Medical College

**Julie Wheeler, OTR/L**

Department of Rehabilitation Medicine, Thomas Jefferson University Hospital

### **James B. Erdmann, PhD Award for Excellence in Interprofessional Education and Collaborative Practice for Administrators/Staff**

**Carolyn Giordano, PhD**

Office of Institutional Research, Thomas Jefferson University

**The Reverend Joseph Leggieri, PhD, BCC, ACPE**

**The Reverend Marianne Robbins, MDiv, BCC, ACPE**

Pastoral Care and Education, Thomas Jefferson University Hospital

**William Bucher, RRT – Honorable Mention**

Intensive Care Nursery, Thomas Jefferson University Hospital

### **James B. Erdmann, PhD Student Award for Excellence in Interprofessional Education and Collaborative Practice**

**Gealina Dun, BS**

Sidney Kimmel Medical College

**Chelsea Gorman, BSN**

Jefferson College of Nursing

**Edwin Lim, BS**

Jefferson College of Pharmacy

**Florda Priftanji, BS**

Couple and Family Therapy, Jefferson College of Health Professions

# TeamSTEPPS® Interprofessional Learning Activity

## Brady McGuire

Department of Occupational Therapy  
Jefferson College of Health Professions  
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Philadelphia, PA

In October 2014 I participated in a TeamSTEPPS® interprofessional (IP) learning activity that has already positively affected my performance in my first clinical field-work rotation. An IP team of professors from the nursing, occupational therapy, medicine, and pharmacy programs hosted the learning activity. Potential difficulty of cross-disciplinary interaction was noted from the beginning as students from each discipline sat in groups despite encouragement to split up. However, with direction from the professors, we formed small interdisciplinary groups and participated in a teamwork-focused icebreaker followed by a lecture about the origins and techniques of the TeamSTEPPS® system. After the lecture we broke into teams and completed two simulated patient encounters in which we were to practice using TeamSTEPPS® language. The Learning Activity ended with a final group session in which the simulation actors reflected upon our teamwork and how they felt during the encounters.

This activity was a learning experience in ways both personal and professional. Personally, I was surprised at the intensity of the simulated situations and my physical reaction including elevated heart rate and flushed cheeks. I was very reluctant to jump in and lay hands on either patient because I had such limited experience in a medical setting. Professionally, finding a role in a situation with multiple players was intimidating at first, but in both situations I focused on supportive and inquisitive interaction with the family member. The other students seemed to have similar difficulty finding their roles due to varying levels of clinical experience. Another takeaway from working with students from other disciplines was that all healthcare professionals,

regardless of title, are fundamentally just regular people with strengths, fears, weaknesses, and the penchant for making mistakes just like everyone else. Because everyone in this situation was a student, we interacted free of the authority hierarchies that typically exist in healthcare settings. Overall, I enjoyed the experience of working on a team in these simulations, and the activity gave me a boost of confidence that I would be able to contribute meaningfully in a medical setting. The activity reinforced my preference for working in a team, and the benefits of having a team response in a crisis were evident.

The TeamSTEPPS® activity has increased my personal comfort and confidence with communicating in my current fieldwork placement at an acute care inpatient hospital by introducing me to specific communication techniques. I use the check back technique most frequently to clarify communication with my supervisor or with other members of the medical team. Most recently, I asked an orthopedic resident to clarify whether a patient status post an ORIF of her tibia still needed to wear the leg brace that she had on when admitted to the hospital. When he gave me the run-down on her brace-wearing regimen, I made certain to repeat it directly back to him to be sure I had it correct. Practicing and discussing the CUS statements in this activity, especially the idea that every member of the team should speak freely despite authority hierarchies, increased my confidence in stating concerns about patient conditions, needs, and safe discharge plans to my colleagues despite my lack of experience. Continuing to practice TeamSTEPPS® techniques in my fieldwork and future work settings will be a key to successful communication in my career.

## Health Mentors Program

### What Our Health Mentors Have to Say About the Program:

"As a member [of the Health Mentors Program], I have seen such growth from the students, not only as individuals, but as a medical team as well."

*-Ana Maria Iglesias*

"I think it is a wonderful program. Being in a health field myself, I know that you new [trainees] need to have experience caring for the sick one-on-one. Without this mentor program, you only have book knowledge and you need hands-on experience, and that is where the Health Mentors Program comes in." *-Rose Williams*

### What Health Mentors Have to Say To and About the Students:

"This was my first time in the program and I really appreciated that the students looked at us as a whole person and not just a diagnosis."

*-Philip C. Moore, Jr.*

"This is my first time with the program and I had an awesome experience. My students were very attentive and listened to me throughout the program. I felt comfortable sharing with them the ups and downs of my life – things the doctors don't normally ask but should." *-Evelyn*



# IPE Grand Rounds Learning Activity

## Adrienne Christopher

Sidney Kimmel Medical College  
Thomas Jefferson University  
Philadelphia, PA

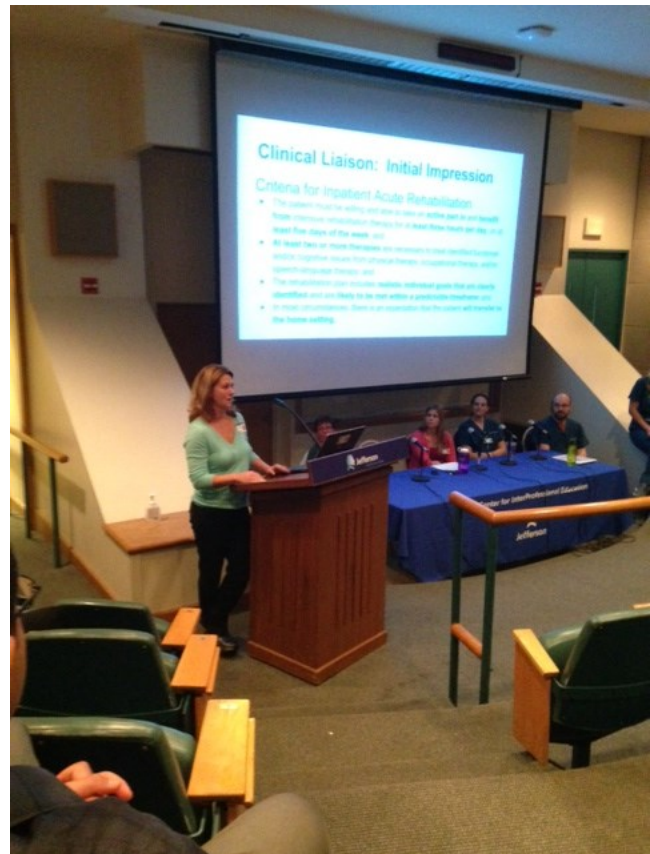
I attended the IPE Grand Rounds hosted by Jefferson Students for Interprofessional Education (JSIPE) with the Palliative Care Team. There were several different health care professionals present on the panel that explained their specific and individualized roles within the Palliative Care team, as well how these roles united to help them function best as a group. The panel demonstrated these specific roles with a case presentation that also helped illustrate some of the conflicts they face on a daily basis, and how they overcome these conflicts to best serve their patients.

Before this panel discussion, I had little idea of what the role of the Palliative Care specialty entailed. This grand rounds session allowed me to learn not only the role of the physician, but also how nursing, social work, and pastoral care all play specific, critical roles. The social worker talked about the importance of educating patients on the importance of an advanced directive, the nurse practitioner about identifying and evaluating a potential plan, the physician about pain management and unifying fractioned care, and the pastoral care resident about identifying spiritual comforts for the patient and family. While all of the panel members were confident in their specific roles, they also all stressed the importance of team collaboration, communication, and compromise. The integrated care in this field is essential, as most often there is no black and white answer, but a large grey area where the course that is best for the patient and patient's family must be delicately identified. Interacting with patients and families while they are often struggling to accept the idea of end of life care seems like an impossibly hard task, both logistically and emotionally. The Palliative Care panel helped me better understand how to navigate these situations, expressing the importance of patience, empathy, and compassion.

When the Palliative Care team expressed to the audience what their role as a specialty was in the hospital, they stressed communication. Later in the discussion they admitted that they are often needed in cases because patients and patients' families have

received a barrage of information from a variety of different specialties. This information overload can make it extremely difficult for patients to make decisions about their care or the care of their loved ones. Palliative Care's role is often to integrate this information and help unify fractioned care in the hospital. What the team posited to all of us, as future health care providers, was to try to minimize this fractioned care within each of our specialties, regardless of what we choose to practice, and integrate aspects of Palliative Care across the health care profession. I hope that as a future health care professional, I will continually strive to make sure my patients are receiving informed, integrated, and compassionate care.

### IPE Grand Rounds



# Interprofessional Education and Care Newsletter



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