

COLLABORATIVE HEALTHCARE

INTERPROFESSIONAL PRACTICE, EDUCATION, AND EVALUATION

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FROM THE EDITORS

We are excited to share with you the summer 2023 edition of our newsletter! As the weather warms, and we celebrate commencements, we reflect upon our accomplishments in the face of many challenges. JCIPE is thankful for our 140 faculty, staff, resident, and student volunteer facilitators who made our student programming possible over the past year. We could not advance team-based care without their support. Additionally, after three years of largely virtual programming, we are thrilled to have brought all of our in-person simulations back to campus during the 2022-2023 academic year. JCIPE said goodbye to some longtime faculty and staff and welcomed several wonderful new team members who have brought with them fresh ideas and perspectives. After interviewing internal and external stakeholders, we are in the process of writing a new strategic plan that will carry us forward towards JCIPE's 20th anniversary in 2027! Finally, we are thrilled to congratulate the faculty, staff, and student recipients of the 2023 James B. Erdmann Awards. These healthcare leaders are working to advance collaborative practice, with the goal of improving health equity and patient outcomes through team-based care. We look forward to seeing where their journeys take them next!

While we have much to celebrate, reading the news about inflation, gun violence, health

disparities, and inadequate mental healthcare can feel disheartening. This issue highlights the efforts of individuals and teams who are working towards a safer, more equitable healthcare system. Dr. Ciera Osborne, a May 2023 graduate of Thomas Jefferson University's Occupational Therapy Doctoral program, interviews Dr. John E. Lewis, Jr., MD, Assistant Professor of Emergency Medicine at the Emory University School of Medicine. Dr. Lewis describes his journey to becoming a physician, and how he was shaped by his faith, his parents, the teachings of the Civil Rights Movement, and eventually, by his patients. He speaks about his lifelong fight against racism, sharing how he uses Black and African music as a method for change. Dr. Lewis stays motivated to continue fighting against the incurable scourge of racism "because the benefits that I have had, that you have had, is because others did not quit." By educating people about the root causes of structural racism, Dr. Lewis believes we can move towards decreasing disparities and increasing health equity.

Health inequities are linked to worse patient outcomes, as are medical errors, which have been estimated to be the third leading cause of death in the U.S. (Makary & Daniel, 2016) Dr. David Nash, MD, MBA, Founding Dean Emeritus and Dr. Raymond C. & Doris N. Grandon Professor of Health Policy at Jefferson College

of Population Health, reflects on his 30-year career as a healthcare system disrupter whose goal is to improve healthcare quality and safety. Dr. Nash believes that "collaboration, coupled with effective leadership training will save lives." Our alumna champion, Kyra Shreeve, a 2022 graduate of Jefferson College of Nursing, agrees. She reflects that "interprofessional teams are integral to providing quality and accessible care to all patient populations." As a nurse at Children's Hospital of Philadelphia (CHOP), Shreeve believes that her experiences with JCIPE as a student provided her "with the confidence to offer meaningful contributions to patient care as an interprofessional team member." One program that Shreeve participated in was the Jefferson Student Interprofessional Complex Care Collaborative (J-SICCC). Our staff champion, Eileen Winter, MSW, LSW, was involved with J-SICCC from 2016 until her retirement this spring. She states that "JCIPE strives to teach students the value of interdisciplinary collaboration and how to work with other members of their team, both to help their patients reach their goals and to contribute to their own professional growth." Before retiring, Winter was a member of the Intensive Care Nursery (ICN) team. We interviewed her and her colleagues about teamwork and collaboration, and what they've learned from each other over the years. They also discussed the case

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of “Baby C,” providing insight into the roles and responsibilities of various team members.

Another clinical team from Jefferson Health describes how they have incorporated twenty-five behavioral health consultants (BHCs), who are licensed clinical social workers or clinical psychologists, across Jefferson’s Primary Care system over the last four and a half years, to address the mental healthcare crisis in the U.S. BHCs provide mental health services to people in the primary care setting, with the goal of increasing access to mental healthcare. Despite implementation challenges, there have been 43,605 clinical consults with BHCs over the last two years. Patients report improved anxiety

and depression symptoms, and providers are satisfied with their contributions.

Finally, three faculty members from TJU describe how JCIPE uses simulation to prepare learners for their future collaborative practice, such as that described by the ICN and primary care teams. JCIPE’s simulations frequently focus on non-technical skills such as teamwork and communication and include in-person programs that use standardized patients or mannequins, low-fidelity simulations delivered via video conferencing, and computer-based simulations that take place in virtual worlds.

We hope that you enjoy this look at the

interprofessional education programming and collaborative practice examples that are taking place at Jefferson and beyond. We thank our contributors and JCIPE faculty and staff for their dedication to JCIPE’s mission. We hope that the summer provides the opportunity to relax and reflect upon your own accomplishments over the past year and we look forward to catching up with many of you back in-person at our biennial conference this November 3-4!

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JCIPE Updates

Health Mentors Program (HMP): The Module 2 small group sessions were completed in April, with all teams presenting on their home visits and the relationship of the 4Ms Age-Friendly framework (what Matters, Mobility, Mentation, Medications) to their Health Mentors. Two teams piloted the new virtual reality home visit experience, including an escape the room component and videos depicting the patient’s interactions with healthcare providers. Health Mentor recruitment for Cohort 17 groups in the fall is underway.

Takeaways

- Each of us (nursing student, medical student, OT student, PT student) has an impact on our patients lives and it is truly important that we listen to our patients and work together to give the best patient care
- Patient care is more than what is at the individual level. We need to look at our patients relationships, community, and society to fully understand our patient and their needs.

The diagram shows four concentric circles representing levels of care: Individual (innermost), Relationship, Community, and Society (outermost).

▲ Health Mentors Program Module 2 Presentations

Team Simulation and Fearlessness Education (TeamSAFE): Both Introductory and Advanced TeamSAFE held in-person sessions this spring semester. **Introductory TeamSAFE**, which teaches students leadership, situational awareness, team support, and communication skills, with a special emphasis on speaking up about patient safety concerns, was held in January. 446 students participated from six professional programs (Medical Imaging & Radiation Sciences, Nursing, Nutrition & Dietetic Practice, Pharmacy, Physician Assistant, and Public Health). **Advanced TeamSAFE**, which reinforces and builds upon the teamwork skills learned in the introductory course, was offered in March. 531 students participated from four professional programs (Medicine, Nursing, Pediatric Nurse Practitioner, and Pharmacy). Students shared that the simulation helped them “learn that everyone and their roles add unique and valuable aspects to the team that contribute to excellent patient care.” A new TeamSAFE simulation

addressing microaggressions is currently being developed and will be piloted in the fall.

The Jefferson Student Interprofessional Complex Care Collaborative:

The J-SICCC program held its annual Wrap-Up event in March with ten Jefferson teams, two external teams from NEPA (Geisinger School of Medicine and Wilkes University), and one from Johns Hopkins University. There was a total of 77 students and 40 faculty advisors from 17 professional programs engaged in the program this year. Students learned about challenges faced by patients with complex health and social needs during their interactions with the current healthcare system. Major student takeaways included learning how to focus on patient-centered care, the importance of interdisciplinary communication, and, as one student stated, that it “makes a huge difference knowing where someone is truly coming from.” Student recruitment for 2023-24 is currently underway, with an in-person Kick-Off scheduled in September.

Interprofessional Teamwork

Obstacles and Challenges

1. Limited access in the team to basic and technical surveys
2. Patients' appointments frequently during working or class hours
3. Delivered care only in different professional fields
4. Complex and conflicting schedules
5. Roles and responsibilities of J-SICCC team to provide care and support for client
 - When should we be supporting or referring to other resources?
 - What systems are already in place that we may not know about?

Strategies and Successes

1. Communicate through text, email, and OneDrive folders
2. One main person to contact patients with support from team
3. Detailed logs of patient interaction so all team members can be aware
4. Clear request when support was needed with tools
5. Use of support from other professionals in our respective networks
 - A. Communication with both client, Community Health Worker and Care Coordinator
 - Sharing our ideas and asking what's needed!

▲ Jefferson Student Interprofessional Complex Care Collaborative Wrap-Up

Team Care Planning (TCP): Two new in-person cases were piloted this spring! The Black Maternal Health case took place in February and included 31 students across five professions (Community and Trauma Counseling, Couple and Family Therapy, Medicine, Physician Assistant, and Public Health). The Exercise Science case took place on the East Falls campus in April, with 11 undergraduate students in an interprofessional education class working with a simulated injured

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high school athlete. This was the first time TCP was executed with undergraduate students, and it was a great success! Students reported that the case taught them to be more present during patient interactions to understand dynamics between patients and support persons. Additionally, there were 35 students from four professional programs (Couple and Family Therapy, Medicine, Occupational Therapy, and Pharmacy) who participated in the March Clinical Discharge case involving Reverend Walker.

Alzheimer's Virtual Interprofessional Training (AVIT): In February, 35 students from five programs (Adult-Gerontology Nurse Practitioner, Medicine, Occupational Therapy, Pharmacy, and Public Health) participated in AVIT simulations through the virtual world, SecondLife®. An additional simulation was offered in March as part of a student's occupational therapy doctoral capstone project and executed for six students. Students who participate in AVIT follow the care of a woman who is diagnosed with Alzheimer's disease. They gain firsthand educational experience that allows them to better learn the roles of patient, provider, caregiver, and observer.

Enhancing Services for Homeless Populations (ESHP): The first-ever facilitator training for ESHP held in April included four new facilitators. Two ESHP cohorts of four students each participated in programming in May over three consecutive weeks of sessions. Through these three different cases, students learn to better understand and meet the needs of people experiencing homelessness through virtual world simulations. Transcription of the Health Professionals Attitudes Toward Homelessness Inventory (HPATHI) cognitive interviews was completed and qualitative review of the data continues through the spring.

Interprofessional Palliative Care Program: The 2023 Interprofessional Palliative Care Program wrapped up in April, with 37 students from 12 professions completing the program. Teams of interprofessional students learned of the importance of collaborative partnerships to ensure access and quality of care for persons with serious illness and/or at the end of life. With the mentorship of 11 faculty and clinical advisors, students learned the essential principles of palliative care through patient-related activities.

Extension for Community Healthcare Outcomes (ECHO): Project ECHO builds primary care workforce capacity and learning communities

by engaging participants in virtual communities with interprofessional healthcare providers who share support, guidance and feedback regarding management of people with complex healthcare conditions. JCIPE currently offers three ECHO series: Medications for Opioid Use Disorder (MOUD), led by experts from Project HOME and Pathways to Housing PA; Integrated Behavioral Health (IBH), led by the Jefferson Enterprise IBH team; and an Age-Friendly ECHO, led by the Center for Healthy Aging. Our MOUD ECHO ran a spring 2023 series and was embedded in the Department of Family & Community Medicine Residency Program for both Jefferson Center City and Northeast residents. Our IBH ECHO also ran a spring 2023 series and our Age-Friendly ECHO started in late May 2023.

Exposure Modules: In winter 2023, several students and faculty members reviewed our Foundations of Interprofessional Collaborative Practice modules and our team incorporated feedback accordingly to all three: Introduction to Collaborative Practice, Teamwork and Communication, and Values, Ethics, Roles and Responsibilities. These modules provide all Jefferson health professions students with a common foundation relative to teamwork in healthcare. Additional academic programs will pilot these multimedia modules in fall 2023.

Jefferson Teamwork Observation Guide (JTOG): JTOG is undergoing testing as it transitions to its new host, Abzooba, an AI and cognitive science organization specializing in advanced analytics, big data, and cloud solutions. This transition should enhance use of the app on campus and also enable broader sales and distribution of the tool. A team of researchers is also working on new analyses in our efforts to continuously study users' teamwork and leadership competencies and to validate the JTOG.

Staffing: The JCIPE team welcomed five new staff members to the team this semester. Dr. Maria Brucato is the new Director of Assessment, Evaluation, and Research. Zawar Jaweed joined the team as the Program Coordinator for HMP, partnering with new Program Assistant Melicia Edmonds, who also works with our virtual world programs AVIT and ESHP. Program Coordinator Reena DePaolo is working with J-SICCC and Program Coordinator Kerry DiNardo manages all simulation programs.

A Provocateur for Improvement



David B. Nash, MD, MBA

Founding Dean Emeritus, College of Population Health
Dr. Raymond C. & Doris N. Grandon
Professor of Health Policy
Thomas Jefferson University

I like to think of myself as an internal champion for improving the quality and safety of medical care that we deliver at Jefferson. A central tenet of our work together at the bedside is that care can never be error free because we're working with people. Our goal should always be to make care harm free.

As a result of my dedication to this notion of harm free care, I would like to review some key milestones in my 30 years as a faculty member and connect the dots between my work and certain events. Here is the punch line upfront: burnout among

healthcare providers coupled with moral injury, structural racism, misogyny, and lack of transparency, are all known contributors to increasing the number of medical errors and harm to patients. In fact, in 2022, the top four leading causes of death in our great country were heart disease, cancer, COVID, and preventable medical mistakes (NIH, 2022)!

I cannot summarize three decades of work in the space allowed here but let me outline half a dozen milestones in chronological order that reflect the arc of the history of our field

and my three decades on the campus.

In August of 1991, I was the second author on a very important paper in the Journal of the American Medical Association (JAMA) (Williams & Nash, 1991) that described the differences in outcomes from open heart surgery in the five major academic medical centers in Philadelphia. This paper (along with papers from other investigators at Dartmouth Medical School) is generally noted as one of the key milestones in the beginning of the outcomes movement.

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When my article debuted, I had to literally hide in the CEO's office at Thomas Jefferson University Hospital, because the surgical leadership at Jefferson at that time was adamantly opposed to the publication of surgeon-specific outcomes for procedures like open heart surgery. This was a very scary time for me personally, as I had only joined the faculty one year before. It was a harbinger for many subsequent events related to promoting transparency, and lifting the veil of secrecy that generally surrounds what physicians, nurses, and other health professionals do every day.

The second milestone was in September of 1999, when the National Academy of Medicine (NAM) published the now famous report, *To Err Is Human* (NAM, 1999). This report made national news for days and I participated in an Associated Press (AP) wire story covered in hundreds of newspapers. When I noted that the book contained some path-breaking research and that it was true that errors were widespread, I was summoned to the President's office at Thomas Jefferson University for a face-to-face dressing down about my comments to the AP reporter.

In September of 2005, I was asked to investigate three pediatric deaths at a children's hospital in Hartford, Connecticut. I dutifully went to Hartford to investigate on behalf of the Commissioner of Health for the state. He then deliberately leaked my private report to the *Hartford Courant* while I was there. I was shocked that my private report ended up on the front page of a major Northeastern newspaper (see Waldman, 2005). I learned a tough lesson about the bare-knuckle politics involved in quality and safety.

In October of 2006, I participated in a press conference at the National Press Club in Washington DC, declaring that we were going to coin a new term called "Hospital-Acquired Infection" based on the work I was doing with the Pennsylvania Health Care Cost Containment Council located in Harrisburg.

This press conference was carried on a page one story in *USA Today* (Appleby, 2006). It resulted in numerous phone calls and difficult subsequent interviews in my attempt to explain how healthy persons admitted to most hospitals in America were at risk for acquiring an infection that they did not have when they were originally admitted.

Additionally, from 2006 to 2017, I had the major responsibility of creating and managing a special one-day program for Sidney Kimmel Medical College (SKMC) third-year students entitled "Interclerkship Day for Quality and Safety" with faculty we recruited from our campus and around the nation. This one-day program exposed the third-year students, for eight consecutive years, to the basic tenets of quality and safety. I learned a lot from the hundreds of students involved in this program over nearly a decade and they were very forthcoming about the errors they personally witnessed, even in the first six months of their clinical training. The results of this Interclerkship Day experience were published in the scholarly quality and safety literature (see Moskowitz and Veloski, 2007).

In 2022, I co-authored what has become a major national bestseller, a book entitled *How Covid Crashed the System, a Guide to Fixing American Healthcare* (Nash & Wohlforth, 2022). I poured my heart and soul into this book, to explain to the public some of the major shortcomings in our \$4 trillion unsafe and highly variable healthcare system.

These six aforementioned milestones contributed to a major self-reflection with my physician-wife of 42 years. As a result, we committed to endowing the first ever trainee prize in improving the quality and safety of medical care at Jefferson. To our knowledge, no comparable prize exists anywhere in our great country to recognize nurses, pharmacists, physicians and others, at all levels of training and expertise, as they contribute to reducing harm in our system.

I embrace the core mission of JCIPE to promote teamwork and leadership training. I am convinced after 30 years of work in this field, that collaboration, coupled with effective leadership training will save lives. I am looking forward to awarding the Nash Family Prize to future generations of healers, as we work across all levels of expertise, to promote our core mission.

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SAVE THE DATE

2023 INTERPROFESSIONAL CARE FOR THE 21ST CENTURY CONFERENCE

NOVEMBER 3-4, 2023





Meet an IPE/CP Staff Champion from Thomas Jefferson University

Eileen Winter, MSW, LSW

Lead Social Worker, Department of Case Management

Briefly describe your work with/related to JCIPE:

I became involved with JCIPE in 2016 as a faculty advisor to the one Jefferson Student Interprofessional Complex Care Collaborative program (J-SICCC, formerly Student Hotspotting) team participating from Thomas Jefferson University. I found the students (medicine, nursing, OT, pharmacy, and two combined MD/PhDs) very engaged and enthusiastic. They took initiative and worked hard to establish connections with their patients. At some point during the year, they began meeting regularly at Scott Library at the end of the day. I joined them when I could, and provided them with direction as they tried to help their patients. It was rewarding to see their interest in the work and their willingness to try interventions I suggested to them to help their patients meet their goals.

By the next academic year, Jefferson became a national hub for Student Hotspotting and expanded to not one, but eight student teams. I became part of the leadership team, where I provided

whatever input I could to the directors of the program as it continued to expand. I also became a Preceptor, a role that has allowed me to interact with a group of student teams throughout the year, helping to guide them in their J-SICCC journey. I continued as a social work Project Lead and Preceptor through this past academic year.

What excites you about this work? Why is IPE/CP important to you?

These two questions are both tied together in my mind, and they are linked to my professional identity and training as a social worker. Communication and collaboration with other disciplines are both critical elements of my work. From my observation over the past five to six years, JCIPE strives to teach students the value of interdisciplinary collaboration and how to work with other members of their team, both to help their patients reach their goals and to contribute to their own professional growth. I find it exciting to work alongside this team whose values so closely align with my own. I believe it is important to model these values for the students in the program, and feel we do that by having an interdisciplinary group of leaders advising the program.



Meet an IPE/CP Alumna Champion from Thomas Jefferson University

Kyra Shreeve, BSN

Alumna, Class of 2022

Briefly describe your work with/related to JCIPE:

As a Jefferson College of Nursing student (JCN), I had the opportunity to be involved in several JCIPE initiatives, including the Jefferson Student Interprofessional Complex Care Collaborative program (J-SICCC, formerly Student Hotspotting) and Team Simulation & Fearlessness Education (TeamSAFE). As a member of J-SICCC, I worked with an interprofessional team of students to support a patient with complex social and healthcare needs. The TeamSAFE training was incorporated within the JCN curriculum, and after participating as a student I was able to volunteer as a co-facilitator. In addition, I had the chance to work with one of the JCN faculty members, Jamie Smith, as well as other JCN nursing students to support a collaboration between JCN, JCIPE and the Hansjörg Wyss Wellness Center in South Philadelphia.

What excites you about this work?

The work that JCIPE does is very exciting to me because it promotes interprofessional communication and collaboration between future healthcare professionals. Not only did this enhance my personal nursing education (I gained so much from the students and faculty members that I worked with in each of the initiatives listed above!), but it also highlighted the impact that effective healthcare teams can have on patient outcomes and experiences.

What have you learned that was new?

So many things! My participation in J-SICCC included regular seminars and training sessions on topics such as motivational

interviewing and harm reduction, which my team was able to directly apply when working with our patient. Through TeamSAFE, I was able to hear from students in other disciplines, practice communicating effectively in healthcare settings, and experience leading an interprofessional team. At the Hansjörg Wyss Wellness Center, I learned best practices for supporting marginalized populations and engaging community members in public health initiatives.

Why is IPE/CP important to you?

Interprofessional teams are integral to providing quality and accessible care to all patient populations. IPE/CP at Jefferson gave me the ability to connect with and learn from students in other healthcare professions while developing the skills necessary to be a compassionate and well-informed nurse and team member.

How do you think you will apply your IPE/CP learning to your future role?

Through JCIPE, I had the opportunity to begin developing several valuable tools, ranging from effective communication to complex care coordination. As a new nurse in the Pediatric Intensive Care Unit at CHOP, these tools inform my interactions with patients, families, and other providers on a daily basis. While I still have a lot to learn, my experiences with JCIPE have provided me with the confidence to offer meaningful contributions to patient care as an interprofessional team member.

Preparing the Healthcare Workforce of Tomorrow through Interprofessional Simulations: A Review of Simulation Technologies used at Jefferson Center for Interprofessional Practice & Education



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Professor, Jefferson College of Rehabilitation Sciences



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Associate Professor, Jefferson College of Pharmacy

Interprofessional (IP) collaborative practice is believed to be an essential component of healthcare system transformation via the "Quadruple Aim" (IPEC, 2016). IP simulations provide invaluable opportunities for learners to practice, discuss, and improve teamwork and communication skills for clinical situations (Thistlethwaite, 2012). Furthermore, IP simulations help students gain a nuanced understanding of, and appreciation for, the roles and responsibilities of colleagues from different professions (Thistlethwaite, 2012). As a result, students increase their understanding of how practice is enhanced as they gain additional perspectives on care and improve their ability to engage in effective IP teamwork (IPEC, 2016). IP simulations allow an opportunity to explicitly address teamwork issues that arise frequently in clinical practice.

We describe three delivery methods for IP simulations used at the Jefferson Center for Interprofessional Practice & Education (JCIPE): in-person, virtual video conferencing (VVC), and virtual reality (VR). Each provides different benefits and challenges. Below we will briefly describe these delivery methods and results from the three programs. For more in-depth review and discussion of the methodology and results, please see previously published studies on these programs (e.g., Forstater, King & Gassman, 2021; Forstater, Sicks, Collins & Schmidt, 2019; Herge & Hass, 2022; Kates, Toth-Cohen & Hass, 2022; King, Gerolamo, Hass, Libros & Forstater, 2021; King & Forstater, 2021; Toth-Cohen, Kates & Hass, 2022; Toth-Cohen & Smith, 2019).

Simulations have been conducted both in-person and via VVC, with increased use of VVC during the COVID-19 pandemic. VR has been used for simulations since the 1960's

(Ziker, Truman, & Dodds, 2021), and while creation and implementation have increased exponentially, fewer IP training programs are conducted with VR than in-person or with VVC. However, recent trends demonstrate an

increased focus on simultaneous use by more than one healthcare profession. (Qiao, Xu, Li & Ouyang, 2021).

Many different technologies encompass VR, which is frequently referred to as extended reality (XR). In this conceptualization, XR serves as the umbrella term for VR, assisted reality (AR), and mixed reality (MR), rather than XR referring to a specific technology (Lee et al., 2021). Additionally, many view specific distinctions between technologies within the VR umbrella. For example, Bracq et al. (2019) categorize VR into:

- 1) screen-based systems commonly used to simulate skilled techniques such as colonoscopy;
- 2) virtual worlds (VW) accessed through laptops or desktops, and in some cases, other devices; and,
- 3) immersive VR, which encompasses delivery through head-mounted displays, (including standalone headsets like Meta Quest) and through Igloo and CAVE systems (shared VR spaces within a physical location).

JCIPE Simulation Programs

Team Care Planning is an in-person simulation in which IP student teams collaborate to develop a treatment plan for a patient, plan a family meeting, and engage in a meeting with a patient and caregiver (standardized patients [SPs]). Following the simulation, students debrief with faculty facilitators and receive direct feedback from SPs. Simulation cases include clinical discharge planning for an elder adult post-stroke and developing a birth plan to

support Black maternal health. Due to the large number of students, some participate in the family meeting while others observe. Our data reveals no differences between participants and observers in the value of the learning activity and teamwork experience (Herge, et. al., 2022). Both groups identify experiential learning as an important theme in response to open-ended questions. Despite the scheduling challenges that are inherent in IP work, the benefits of in-person simulations include the richness of in-person discussions and the opportunity to learn to react to elements in one's surroundings, including patient and caregiver body language.

Team Simulation and Fearlessness Education (TeamSAFE) is an in-person simulation in which IP student teams apply teambuilding and communication techniques to patient encounters using the framework of Team Strategies and Tools to Enhance Performance and Patient Safety (TeamSTEPPS®), a national patient safety toolkit. During the COVID-19 pandemic, TeamSAFE simulations were conducted via VVC. Despite the challenges of VVC simulation, including difficulty suspending disbelief and engaging students in an online learning environment, students performed similarly on a pre-post knowledge assessment. Furthermore, they endorsed similar increases in their comfort levels relative to speaking up to advocate for patient safety, compared to pre-pandemic students. (Internal data available upon request.) Additionally, virtual delivery allowed for easier participation for students and



▲ Skill-building with Advanced TeamSAFE in-person simulation to improve patient safety

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facilitators located on different campuses and less complicated scheduling of sessions due to the lack of travel time for participants.

Virtual Reality (VR) programs presently used within JCIPE focus on training IP teams of health professions students and staff to work with vulnerable populations. Programs include Alzheimer's Virtual Interprofessional Training (AVIT), which focuses on persons with dementia and their caregivers, and Enhancing Services for Homeless Populations (ESHP), focusing on unhoused persons, both emphasizing communication, teamwork, and leadership development (Bracq et al., 2019).

An important aspect of VR simulations is their fit with intended educational objectives, particularly their focus on training students in complex procedural/technical skills versus non-technical skills (NTS) such as communication, teamwork, and leadership (Bracq et al., 2019). Both technical and NTS may be a focus in a given VR simulation, but typically one or the other predominates. Presently, JCIPE emphasizes the development of NTS in its VR programs. AVIT and ESHP use the VW SecondLife® as the platform, due to its capacity to incorporate simultaneous participation by students from different geographic locations.

Both AVIT and ESHP use a case format to structure student learning, with consumer, patient, provider, and observer roles (Okun & Kantowicz, 2014). This process of enacting different roles is considered crucial for building empathy and other key professional NTS (Rosland et al., 2022).

AVIT is designed to meet the needs of specific learners: students follow a person with dementia and her caregiver over time, from mild stage/initial diagnosis through middle- and late-stage dementia, in a series of three cases. AVIT is also designed to aid practicing clinicians, who complete one case.

ESHP consists of three distinct cases showing mobile and fixed-site outreach with different persons experiencing homelessness (PEH): a teenager with schizophrenia and substance use disorder; a 58-year-old Iraq war veteran who became homeless following job loss; and a mother with three young children who left her home for a transitional housing shelter after experiencing domestic violence. All cases focus on harm reduction techniques, strategies for using and customizing appropriate resources, and engaging and collaborating with PEH through motivational interviewing.



▲ Clinical Pharmacist conducts a medication review in Second Life

AVIT and ESHP programs use a sequence of pre-briefing, simulation, debriefing, and evaluation. Evaluations include a continuous quality improvement approach to enhance the programs by eliciting feedback from stakeholders (students, staff, administrators, and facilitators). Both programs were developed in collaboration with community partners, including a continuing care retirement community (The Hill at Whitemarsh) for AVIT and a housing first organization, Pathways to Housing Pennsylvania, for ESHP. Both AVIT and ESHP have demonstrated consistent pre-post gains in self-efficacy over time (Toth-Cohen & Smith, 2019). 84-87.5% of students rate their satisfaction very good or excellent (Toth-Cohen, et. al., 2022). The main challenge associated with VR simulations is that some students may have difficulty using or accessing the technology.

Conclusion

Each simulation delivery method has unique challenges and benefits. VR is a rapidly changing field with an incredible range of opportunities for meaningful development to accomplish educational goals and optimally "grow" VR's use for IPE.

Data reviewed above indicate that each simulation method fosters learning (see cited work on p. 6). Therefore, when selecting which method is right for a given scenario, educators should consider the learning objectives they hope to achieve; the characteristics of their learners, including

varying course and clinical schedules across programs, geographic location, and access to technology; and the instructor's resources, including interest, time, and money. Flexible frameworks and perspectives are essential for robust development and use. Key tenets for ongoing development that will take IPE into the future include multi-purpose usage for different learning venues and strategies, as well as expanding the number of participating disciplines while optimizing integration of IP simulations into curricula.

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Spotlight on Interprofessional Clinical Teams

Take a closer look at a clinical team at Thomas Jefferson University Hospital and how they practice interprofessionally every day!

The Jefferson Intensive Care Nursery (ICN) offers advanced care for infants who are born under critical circumstances or require specialized treatment for medical, surgical, or cardiac disorders. JCIPE interviewed the ICN team about several topics, including their roles, their interprofessional dynamic, and what they have learned from each other over the years. The team also reviewed the case of "Baby C" during the interview. (Responses have been edited for length and clarity.)

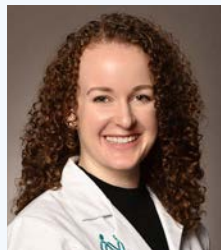
MEET THE ICN TEAM



William Bucher, RRT-NPS, Lead Therapist, Pulmonary Care



Alicia Graf, MA, CCC-SLP, Speech Language Pathologist, Intensive Care Nursery



Margaret Lafferty, MD, FAAP, Associate Clinical Director, Intensive Care Nursery



Dot McElwee, MSN, NNP-BC, Neonatal Nurse Practitioner



Elizabeth Przychowicz, RN, BSN, CBC, Intensive Care Nurse



Marie Snyder, PT, DPT, PCS, Physical Therapist, Intensive Care Nursery



Eileen Winter, MSW, LSW, Social Worker, Case Management

What do you find most meaningful or rewarding about your work?

Graf: One of the greatest challenges for these babies is learning how to eat, so helping them learn to eat and families learn to feed. And sharing the joy when babies achieve that goal and can go home.

Przychowicz: I see people at their worst, their angriest, and I meet them with understanding and compassion, and get them to a better place.

Lafferty: The connections and relationships we form with everyone we work with, including the families of the patients.

What are the main benefits of providing team-based care, for you or for your patients?

Bucher: Learning from the whole team. Everyone has different ways to approach situations, and learning from individual healthcare professionals is vital.

McElwee: Everybody brings something different to the table, so whatever your discipline, I'm going to learn from you that day.

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Winter: We all have different backgrounds and expertise and when we bring all that together around the patient's particular problem, I think we can do a much better job than anybody could do alone.

Can you share an example of how your team works together?

Bucher: Cardiopulmonary resuscitation. It's controlled chaos. Everybody has a role, they know what the role is, they do it, they do it very well, and they perform it precisely as they should.

Lafferty: We do daily rounds at the bedside. Head to toe, we talk about each patient, the diagnoses, what is the best next step for the day.

Przychowicz: Every day, twice a day, we come together as a team, including parents if they are there. We discuss numbers, the baby, the plan, where we are at, what we see. It helps keep everybody on the same page.

What are the key skills or attributes that enhance teamwork in your setting?

Graf: Communicating effectively, trust, respect, and a mutual understanding of

the goal. All that leads to constructive and collaborative problem solving.

McElwee: Listening, communication, but also leave your ego at the door. Everybody has something to say, even parents. They are all part of the decision making, part of the plan, and part of the team.

Snyder: Listening, flexibility, communication, but also advocacy. Knowing when to speak up for your patients, teaching parents to advocate for their babies, and advocating for yourself or the team.

What have you learned from providers in other fields or disciplines?

Snyder: A lot of medical information outside my specific field, understanding medical conditions, different equipment, what works and does not work.

Winter: I have picked up a lot of medical information. When patients are diagnosed with something or if we're talking about a difficult delivery, understanding what that means from the people I work with is critical.

CASE REVIEW

Baby C was born prematurely at 34 weeks and four days. The mother had a history of hepatitis C and some IV drug use. The mother presented in preterm labor and had previous C-sections, so the baby was born via C-Section. Prior to delivery, the mother was noted to be intermittently somnolent, or abnormally drowsy. She had used heroin within the few hours preceding delivery and was also diagnosed with chorioamnionitis, an infection of the placenta and amniotic fluid.

Baby C required respiratory support in the delivery room but was stabilized and taken to the nursery. The team's diagnosis was respiratory distress (or desaturations of unknown etiology), prematurity, and risk for sepsis, hepatitis C exposure, and neonatal opiate withdrawal. In addition, this mother's breast milk was a concern for this baby. After monitoring Baby C's progress and evaluating treatment, the team coordinated a safe plan for baby and parents.

[Take a closer look at the ICN team](#)

Interview of John E. Lewis, Jr., MD, MS, FACEP



John E. Lewis, Jr., MD, MS, FACEP



Ciera Osborne, OTD
OTD Alumna, College of Rehabilitation Sciences

By Ciera Osborne, OTD, submitted as a doctoral candidate in Occupational Therapy

Dr. John E. Lewis, Jr., Assistant Professor of Emergency Medicine at the Emory University School of Medicine, presented the keynote at the 2022-23 J-SICCC Kick-Off event, exploring the systemic racism fueling the health disparities in our society in a raw, real, and electrifying way. I sat down with Dr. Lewis to continue the conversation. Through his sharing, Dr. Lewis helps us understand our own journeys, what drives us, and how we can improve our healthcare teams and patient interactions. This interview dives deeper into the roots of our disconnections to find the only treatment that will work to make

the changes we want to see—empathy and vulnerability. When we are presented with what divides us, it is the work of looking for what connects us, both the good and bad, which makes the difference.

Can you describe your journey of becoming a healthcare provider?

My journey entailed a life-hood fortified with science and humanitarianism through the church. I realized I was baptized and bathed in this ethos of science and social justice.

I said, "What could I do with all this love of and proclivity for science and still follow this burning passion to better my fellow man?" That's when I thought about being a physician. I faced racism along the way and realized all that I experienced was what those before me had fought, and it was my responsibility to fight also. From that point on, I continued to march further and higher to knock down barriers for those who were coming behind me.

When did you find your "voice" and how did you use it to influence the work you do?

My boldness to speak came early in my life. As my parents raised me in the church and with the teachings of the Civil Rights Movement, I was always prepared to speak

the right and the good. The fear was not there, but understanding how to get someone's ear was a lesson I learned as an attending physician as patients came into my emergency department: you have to walk alongside the people. I found my voice in listening to the voices of others.

What was your inspiration for using hip hop music and culture in your movement toward connecting the gaps that communities of color experience with the healthcare system?

American music has always been a solvent or method for change. The African drum would communicate it was time to move away and that developed into the Negro Spirituals. The Renaissance of the 1920s created jazz, the soundtrack for Black excellence. Then we progressed to soul music and R&B in the 1960s. And the music of my generation is hip hop. Can't we now tie that to the next Civil Rights Movement, which I believe is health equity? Let's talk about health, about social economics, and let's tie it to the thing that is going to make people dance to it so the next generation will say, "Of course I know that there's structural racism in healthcare."

Continued on page 10

How do you keep yourself motivated in the movement you've created in moments where it feels like the needle toward progress won't budge?

The needle does not always move, you are exactly right. Change is constant, the direction is not. The laws of the universe say that things will tend to go from a state of order to disorder unless you put energy into the system. So, I realize when things are falling apart, we need to put external forces into it, and for me, that is my faith. While it is disheartening at times when you see the needle move backwards, this current Black renaissance we are experiencing gives people a voice to speak. But that is only temporary. Those voices will be silenced because that is what history and science tell us. And that tells me that we have to do it again, get up on our platforms, rally again, march again. That is how I keep myself motivated because the benefits that I have had, that you have had, is because others did not quit. We may not always win, but at least we keep the score close.

In terms of keeping you motivated, do you have a go-to song for us?

These are my three songs now: "A Change is Gonna Come" by Sam Cooke is the anthem. It talks about the humility of birth, the unsurety of faith, the determination that change will have to come. "A Song For You" by Donny Hathaway talks about the roles we play, the sincerity and imperfection in those roles, because relationships are what build society. And O.C.'s "Time's Up." It talks about honesty and sincerity in our messaging.

If remnants of racism can never be fully eradicated, how do you wish to see current and future healthcare teams practicing giving their patients the highest quality of care despite the systemic and engrained disparities?

I see racism as a symptom, as all -isms are, of a greater disease: selfishness or an unchecked self-interest. This is something that manifests itself in our own bodies and actions. While it is an incurable disease, it is one that can

be treated and must be addressed. We are always in remission for these self-serving machinations. I instinctually want what is going to allow me to survive and flourish, even if at the detriment to another group of people. That is why I don't think racism is curable; I don't think our self-serving interests as human beings are curable. If a person is racist or sexist, that is not the root cause. We need to educate the masses on why these things happened and how they continue to recur and manifest and metastasize. Recognize the root causes. When we educate the masses, you will see equity, you will see disparities decrease. It will not disappear because those things are always in play, but you will see an alignment.

[Dive deeper into Ciera Osborne's interview with Dr. John E. Lewis](#)

2023 JAMES B. ERDMANN AWARD RECIPIENTS

The Jefferson Center for Interprofessional Practice & Education (JCIPE) congratulates this year's interprofessional education (IPE) and collaborative practice (CP) award winners and thanks them for all of their efforts to support and advance this work on campus and beyond. Their contributions are immeasurable!

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College of Rehabilitation Sciences
Thomas Jefferson University

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Expanding the Primary Care Interprofessional Team: Creating Space for Behavioral Health Consultants



**Rachelle Rene, PhD,
BCB, HSMI, CGP**

Clinical Assistant Professor
Enterprise Director, Integrated
Behavioral Health



**Mollie Cherson,
MPhil, LCSW**

Lead Behavioral Health
Consultant, Jefferson Health
– North and Central Regions

Statement of issue or problem addressed

Despite a growing need for mental and behavioral health services, access to these services has been limited due to constraints in insurance coverage and location of services outside of medical care. As a result, mental and behavioral health needs have frequently fallen to the primary care system to support.

Background

The primary care setting has been the de facto mental health provider for many, treating and managing most patients with depression and anxiety diagnoses (Kessler, 2008). Nearly 21% of adults in the United States live with a mental health disorder (Carbonell, et al., 2020). Despite the increasing prevalence of mental illness, mental healthcare needs are often unmet due to a myriad of systemic, structural, and cultural barriers. Since the emergence of COVID-19, growing research shows evidence of continued burden to the primary care setting (Kanzler & Ogbeide, 2020; Rajkumar, 2020). In addition, behavioral health workforce shortages, especially in psychiatry, are widespread across the U.S., leading to limited options for care, excessive wait times for services, and an increased travel burden to access care. As a result, integrated behavioral healthcare using the Primary Care Behavioral Health (PCBH) Model, has been an effective approach in caring for individuals with mental health conditions diagnoses (Robinson & Reiter, 2016) and bringing psychotherapy treatment modalities to the primary care setting (Sawchuk, et al., 2020).

The PCBH model has been widely implemented in a number of healthcare and community settings, including federally qualified health centers, the U.S. Veterans Health Administration, the U.S. Department of Defense, and large academic health centers. In this model, the behavioral health provider works

as a member of the primary care team and is referred to as a Behavioral Health Consultant (BHC). The BHC delivers a variety of evidenced-based interventions for a range of behavioral health issues across the lifespan, focusing on symptom reduction, functional improvement, and quality of life. BHCs provide high volume, accessible, and team-based services (Robinson & Reiter, 2016). The presence of BHCs in primary care practices enhances and expands the interprofessional team's scope of care delivery for many patients otherwise not seeking behavioral health services outside this setting.

Methodology

Jefferson Health has taken the initiative to incorporate the PCBH Model across its Primary Care system over the past 4.5 years. Sixty primary care practices were accepted into the Center for Medicare and Medicaid's 5-year Comprehensive Primary Care Plus demonstration program (2017-2021). This program has continued to expand through the Primary Care First initiative.

Currently, there are 25 BHCs, including licensed clinical psychologists and LCSWs across the Jefferson Enterprise. They support 60+ primary care offices with 300+ individual providers, including MDs, DOs, and NPs. BHCs provide individual, family and group therapy within the context of the PCBH model, as well as provide psychoeducational support and clinical consultations for the primary care team.

Results

Over the past five years and specifically during the COVID-19 pandemic, there has been a steady increase of utilization of the Jefferson BHCs to provide mental health services to patients. Since the transition to the use of Epic two years ago, there have been 43,605 clinical consults with BHCs ranging from referrals for anxiety, depression, grief, and PTSD; diagnostic clarification, diabetes management and chronic pain, among others. Of these, 8,234 were for an initial visit and 35,371 for follow-ups.

Patients who have met with a BHC, on average, experienced a near 70% decrease in their PHQ-9 (depression screening tool) and GAD-7 (anxiety screening tool). Primary care providers have also expressed satisfaction with having BHCs as part of their interprofessional team. In addition to providing patient care, the BHCs have also supported Jefferson employees through

delivery of psychoeducation and wellness support groups focused on a myriad of topics.

Discussion

Standardizing a new model of care over the past five years has benefited patients and providers and incurred many lessons. For some practices and providers, it took time to learn how to collaborate with a BHC. Now, many providers report the indispensability of having a BHC on the team and appreciate the ease of access to this resource. Patients have also reported the benefit of meeting with a BHC in the context of their medical care to address behavioral health needs. Additionally, the use of telemedicine has greatly expanded our ability to meet patient and provider needs outside of the office setting. While the use of telemedicine came with a steep learning curve and quick pivots during the pandemic, our team has navigated the necessary adjustments and now delivers care both in-person and via telehealth.

Despite our successes, our team of embedded BHCs has faced program implementation challenges involving clinical workflows, concurrent documentation, template development, and provider administrative pain points or burdens. What we have learned is the incredible need for patience, flexibility and willingness to work collaboratively across many different groups and departments to ensure effective, sustainable and meaningful outcomes. While there is still more work to be done, we have established a solid foundation upon which we can continue to effectuate change.

Conclusion

The opportunity to grow this program within primary care and provide the additional support needed to our primary care providers in managing the complex needs of our patient community is vast. The Jefferson Integrated Behavioral Health Team has found this interprofessional approach to be valuable for patient care. The impact of integrating behavioral health within the primary care system is well supported, and this interprofessional approach should continue to grow if we are to effectively meet the needs of our growing community.

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