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Bridging the Quality Chasm: Interprofessional Teams to the Rescue?

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Interprofessional education for collaborative practice, also referred to as education for "team-based healthcare," is a recent innovation in US health professions education.[1] Several specialties in medicine support this approach to care, for example, geriatrics, but educational preparation to deliver team-based care remains underdeveloped in the US. Will that change?

INTERPROFESSIONAL COLLABORATIVE PRACTICE IN THE NEW MILLENNIUM

The year 2000 may have marked the beginning of a significant migration from physician-centric health care delivery to team-based models in the US. If this is so, many physicians barely noticed it at the time. It was jump-started by an influential Institute of Medicine (IOM) report showing that medical errors are a leading cause of adult deaths in the US.[2] This was disturbing news to both the general public and the health care community at the time.

In 2003, the IOM issued another report in their *Quality Chasm Series*, entitled "Health Professions Education: A Bridge to Quality." A key recommendation was that all health professionals should be educated "to deliver patient-centered care as members of an interdisciplinary team" to address some of the quality-of-care issues highlighted in the year 2000 report.[3] These ground-breaking IOM reports connected practice change and educational preparation.

DRIVERS OF TEAM-BASED HEALTH CARE DELIVERY

The advocacy of the IOM and others for a "sweeping redesign of the entire health system," including migration from a physician-centric system to a team-centric system of health care delivery, has several drivers, including:

- Cost containment issues. Effective team-based health care may be less costly health care.
- Quality and safety issues. Fragmentation of services and ineffective communication among service providers downgrades quality and jeopardizes safety.
- Primary care physician shortages. Team-based primary care may enhance access, comprehensiveness, and physician "joy" in care.[4]
- Interprofessional education collaboratives publishing core competency education frameworks for team-based care preparation.[5]

WHAT DEFINES A HEALTH CARE TEAM?

"Core" teams include doctors, nurses, and possibly pharmacists or social workers. Depending on the clinical situation, others, for example, physical, occupational, or speech therapists, physicians' assistants, dentists, or non-professionals, could be added to the mix. Teams can be large or small, with broad scope for care delivery, or focused on specific patient needs. Team members may work in centralized locations or function as "virtual" teams, linked together by telecommunications systems. Specialists may participate in numerous teams, entering and leaving them on an "as needed" basis.

Whereas flexibility in health care team design contributes to its practicality from an organizational standpoint, flexibility has its own downsides and can complicate both educational and practice issues. Wynia et al[6] note that "the extreme heterogeneity in tasks, foci, and settings presents a challenge to defining optimal team-based health care."

PRIMARY CARE PROVIDERS IN HEALTH CARE TEAMS

Debate about team-based care intersects with serious concerns over primary care provider shortages. Alpert[7] recently wrote a prescription for normalizing our anemic primary care provider workforce, which invokes expanded use of health care teams. His idea is to expand the primary care provider workforce by: 1) adding a considerable number of nurse practitioners and physician's assistants into the primary care mix; 2) encouraging these professionals to work in groups; 3) having primary care doctors as the

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leaders of these hybrid (multi-profession) teams; and 4) letting most of the routine care be delivered with minimal physician oversight.[7] Retchin[8] has noted that in lower "intensity" settings, like primary care, "the structured authority is less defined" and also creates greater opportunities for "co-managed" care.

DEVIL IN THE DETAILS

Regulatory issues and billing practices are key challenges for the widespread implementation of health care team-based practices. Creation of maximally efficient and cost-effective co-managed team-based models also may require: rewriting the scopes-of-services of the non-physician team members and aligning them with those of physician team members; creating standards of care for cross-coverage of restricted tasks; and authoring of group billing codes. Doctors', nurses', pharmacists', and other fees would be bundled and then equitably shared by team members.

Medical practice is changing and the future shape of the health care enterprise remains uncertain. Currently, educational flexibility and responsiveness are not characteristic of our current health profession, discipline-defined, educational silos (eg, medicine, nursing, pharmacy). The dynamic nature of medical practice change demands greater flexibility in medical education and the closer alignment of traditional educational silos in order to optimize the benefits of health care in the future.

Ronald S. Weinstein, MD[a]
Barbara F. Brandt, PhD[b]
John H. V. Gilbert, CM, PhD[c]
Madeline H. Schmitt, PhD, RN[d]
[a]*College of Medicine*
Mel and Enid Zuckerman College of Public Health
College of Pharmacy
University of Arizona
Tucson
[b]*College of Pharmacy*
University of Minnesota
Minneapolis
[c]*College of Health Disciplines*
University of British Columbia
Vancouver, BC
Canada
[d]*School of Nursing*
University of Rochester
Rochester, NY

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