Nexus Innovations Network
Project Compilation
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National Center Update on the Future of IPE
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THE ROLE OF INTERPROFESSIONAL FACULTY DEVELOPMENT IN IMPROVING COLLABORATIVE PRACTICE BEHAVIOR COMPETENCIES

STATE: Alabama

MEMBER SINCE: February 2016

PARTNERS:
University of Alabama at Birmingham (UAB) Center for Interprofessional Education and Simulation
UAB School of Dentistry
UAB School of Health Professions
UAB School of Medicine
UAB School of Nursing
UAB School of Optometry
UAB School of Public Health
UAB College of Arts and Sciences, Department of Social Work

OCCUPATIONS REPRESENTED: At present, faculty from clinical laboratory sciences, dentistry, medicine, nursing, optometry, physical therapy, physician assistant studies, and social work.

OVERVIEW: This project focuses on the impact of an intensive 4-day faculty development course on simulation debriefing. The intensive course will include didactic and reflective exercises for use in a simulation setting. Curricula for the schools of medicine, nursing, and health professions have pre-existing simulation experience built in, and this course creates a targeted approach to increase interprofessional engagement through training. It is expected that benefits of the course will extend into classroom and clinical practice experiences for students.

The outcomes measured among participating faculty will include changes in perceptions of interprofessional collaboration and use of interprofessional competencies. These core outcomes relate specifically to conflict resolution, negotiation, use of teamwork tools and strategies, navigation of difficult conversations, and best practices in co-debriefing. Themes will include mutual appreciation, respect and curiosity. Outcomes among students will be studied in a later project.

PROJECT STUDY QUESTION:
• For UAB faculty and staff, does receiving standard or additional intensive training in simulation affect (a) perceptions of IP collaboration, and (b) IP behaviors at specified intervals, compared to faculty who do not receive simulation training?
IMPROVING HEALTH OUTCOMES IN INDEPENDENT SENIOR HOUSING THROUGH AN INTERPROFESSIONAL HEALTH AND SOCIAL SERVICES CENTER

STATE: Arizona

MEMBER SINCE: May 2015

PARTNERS:
Arizona State University (ASU)
The Collaboratory on Central, formerly known as The Interprofessional Center for Health and Social Services at the Westward Ho

OCCUPATIONS REPRESENTED: Students and faculty from nursing, nutrition, recreational therapy, and social work.

OVERVIEW: The Collaboratory on Central, formerly known as The Interprofessional Center for Health and Social Services at the Westward Ho is a student-run, faculty-supervised training unit that provides onsite supportive services to 300 residents of a low-income senior housing community in downtown Phoenix (the Westward Ho). Through participation in service learning experiences, students build skills in interprofessional collaboration as well as skills in their individual discipline, while increasing access to health and psychosocial care for housing community residents, the majority who are under-served older adults living with chronic illness and disability.

The initial evaluation of The Collaboratory on Central focuses on students’ knowledge and perception of interprofessional practice, their development of practice skills for interprofessional collaboration, residents’ health and psychosocial outcomes (i.e. falls, blood pressure levels; sense of community, quality of life), and the level of association between students’ interprofessional learning and residents’ outcomes.

PROJECT STUDY QUESTION:
• What are the effects of participating in a service learning experience on the knowledge, skills, and attitudes (values) of health professions students related to interprofessional collaboration and practice?
• What are the effects of receiving ongoing onsite health and social services from health professions students on residents’ baseline health and psychosocial measures?
• What is the strength of the relationship between health professions students’ development of interprofessional collaborative skills and Westward Ho residents’ longitudinal health and psychosocial outcomes?
STUDENT HEALTH OUTREACH FOR WELLNESS (SHOW)

STATE: Arizona

MEMBER SINCE: May 2015

PARTNERS:
Arizona State University (ASU)
Northern Arizona University (NAU)
The University of Arizona (UofA)
Health Care for Homeless (HCH),
Maricopa Department of Public Health
Human Services Campus
The Arizona Nexus Macy Project

OCCUPATIONS REPRESENTED:
Students and professionals from health-related fields including, but not limited to: audiology, medicine, nursing, nutrition, occupational therapy, pharmacy, physical therapy, physicians assistants, psychology, social work and speech and hearing. Students and professionals from non-health related professions including, but not limited to, business, computer science, engineering, law, and communications.

OVERVIEW: SHOW is a student-run clinic serving the health and social needs of vulnerable populations in the local Phoenix community. Students and faculty from multiple health and non-health professions across Arizona’s three state universities have come together to increase access to care and services for vulnerable and underserved homeless individuals. SHOW includes education and experience in collaborative practice. Students are guided by faculty and supervised by qualified clinical preceptors.

The initial evaluation of the SHOW experience focuses on workforce development, interprofessional practice readiness, attitudes toward homelessness and client satisfaction. Projects that evaluate health outcomes associated with chronic illness and costs of care are being developed.

PROJECT STUDY QUESTION:
• What is the effect of student interprofessional team practice on attitudes toward homelessness for students and preceptors?
• What is the effect of student interprofessional team practice on student perceptions of their readiness for interprofessional practice and their evaluation of preceptor support for interprofessional practice over time?
• What is the effect of student interprofessional practice on satisfaction of the client population with their health services?
COMMUNITY HEALTH MENTOR PROGRAM: A ONE-YEAR INTERPROFESSIONAL MENTORSHIP

STATE: Arizona
MEMBER SINCE: July 2016

PARTNERS:
University of Arizona (U of A) College of Medicine - Phoenix
Northern Arizona University (NAU) College of Health & Human Services

OCCUPATIONS REPRESENTED: Students and faculty from four programs: medicine, occupational therapy, physical therapy and physician assistant studies.

OVERVIEW: The “Community Health Mentor Program” (CHMP) reflects the alignment of health professions education where the students learn from their assigned community health mentor who has a chronic disease and/or disability about their experience as a patient within the healthcare system and their community, as well as their role within an interprofessional team. The students meet with their assigned mentor eight times over the course of the one year. This project collectively forms a 'nexus' partnership between two state academic institutions, interprofessional student teams, and a defined population of residential community-based consumers of healthcare. Outcome measures for this project include scores on the Interprofessional Education Collaborative Competency Survey and the Community Health Mentor Survey. Qualitative analysis will be based on students’ written reflections to questions about the value of collaborative care, community needs and barriers to healthcare as well as advanced directives for patients.

PROJECT STUDY QUESTION:
• Among four health profession programs, what is the benefit of participation in the Community Health Mentor Program over a twelve-month period for both health professional students and community health mentors?
INTERPROFESSIONAL EDUCATION COMMUNITY OF PRACTICE: CONNECTING IPE TRAINING TO COLLABORATIVE PRACTICE IN COMMUNITY HEALTH SETTINGS

STATE: Arizona

MEMBER SINCE: May 2015

PARTNERS:
AT Still University, School of Osteopathic Medicine in Arizona (ATSU-SOMA)
El Rio Community Health Center, Tucson, AZ
HealthPoint Community Health Center, Seattle, WA

OCCUPATIONS REPRESENTED: Students from behavior health, osteopathic medicine and pharmacy

OVERVIEW: With the goal of improving health care outcomes, this intervention supports collaborative practice in community-based primary care clinics that serve underserved populations. In Phase 1 of the project, an interdisciplinary group of preceptors will complete the IPE Faculty Development: Train-the Trainer CoP program, and develop lesson plans. In Phase 2, these preceptors will supervise students who are part of interprofessional teams at El Rio Community Health Center and HealthPoint Community. In Phase 3, the effects of these collaborative practice efforts will be assessed. The intervention thereby creates a nexus between ATSU-SOMA and the community clinics.

PROJECT STUDY QUESTION:
• Phase 1: How does the IPE Faculty Development: Train-the Trainer CoP program affect preceptor lesson planning and lesson design?
• Phase 2: How do IPE lessons delivered by the preceptors who completed the training affect student satisfaction, process of care skills, collaboration (teamness), and community oriented primary care?
• Phase 3: What is the effect of the team care intervention processes, which are a product of Phase 1 and Phase 2, on patient health, health utilization outcomes, and patient satisfaction with care services in a population of adult patients with chronic morbidities and/or disabilities?
AN INTERPROFESSIONAL CURRICULUM TO IMPROVE QUALITY AND SAFETY

STATE: Colorado

MEMBER SINCE: July 2014

PARTNERS:
University of Colorado Anschutz Medical Campus
University of Colorado Hospital

OCCUPATIONS REPRESENTED: Students and professionals including nurses, pharmacists, physicians, physical therapists, social workers, and advanced practitioners.

OVERVIEW: This educational intervention is intended to drive clinical change. The curriculum focuses on patient safety, the patient experience and continuous quality improvement (QI). Interprofessional student teams, together with the interprofessional faculty QI teams, experience healthcare on the front lines by interviewing and observing patients, and then identifying quality gaps in clinical care. The teams make recommendations on how to improve clinical care, and use quality improvement tools to analyze their quality improvement recommendations. These solutions are offered to frontline clinical units to be used for future QI projects. The three core experiences with this curriculum are 1) understanding the patient experience by interviewing patients, 2) patient safety event analysis and reporting, and 3) analyzing quality improvement solutions with integration of students into the clinical leadership teams of the University’s Institute for Healthcare, Quality, Safety and Efficiency. Outcome measures are derived from student surveys, as well as clinical outcomes, including reported adverse events and safety intelligence reports, and quality improvement recommendations in the form of an executive summary.

PROJECT STUDY QUESTION:
• How does an interprofessional curriculum impact gaps in transitions of care, improve safety and the quality of care?
INTERPROFESSIONAL COMMUNITY-ACADEMIC RESOURCE ENGAGEMENT (I-CARE) ADULT DIABETES MANAGEMENT PROJECT

STATE: Colorado
MEMBER SINCE: December 2015

PARTNERS:
Sheridan Health Services, University of Colorado College of Nursing
University of Colorado School of Dental Medicine
University of Denver Graduate School of Social Work
Metropolitan State University Dietetics Program

OCCUPATIONS REPRESENTED: Students and professionals from diabetes education, dietetics, nursing, pharmacy, and social work.

OVERVIEW: This intervention project centers on care of approximately 120 diabetic adults via an interprofessional care team. Most of the individuals in this patient cohort have experienced uncontrolled Type 2 diabetes. Self-management education and a group visit model are components of the intervention. The care team also incorporates shared decision making models that include the patient in decisions. Better preventive care and enhanced self-management are intended outcomes, and pre-intervention data were collected through the health system’s 2014 quality care indicators.
Outcome measures associated with patients will include A1C, BMI, lipids, blood pressure, medication adherence, and patient satisfaction. For the health professions students, measures for satisfaction and knowledge gain will be collected. Students’ perceptions of interprofessional education and collaborative practice will be captured using a validated assessment tool.
Sheridan Health Services is a nonprofit, nurse-managed federally qualified health center. It operates a community health center and a school-based clinic. Special services include child and teen care, behavioral health, dental care, women’s health, and case management. Its board includes clinic users and consumers from the Sheridan community.

PROJECT STUDY QUESTION:
• What is the effect of increased interprofessional team based care and collaboration on patient health indicators, patient satisfaction and student knowledge?
INTERPROFESSIONAL COMMUNITY-ACADEMIC RESOURCE ENGAGEMENT (I-CARE) CHRONIC PAIN MANAGEMENT PROJECT

STATE: Colorado

MEMBER SINCE: December 2015

PARTNERS:
Sheridan Health Services, University of Colorado College of Nursing
University of Colorado Denver Graduate School of Social Work
University of Colorado Skaggs School of Pharmacy and Pharmaceutical Sciences
University of Denver Graduate School of Social Work

OCCUPATIONS REPRESENTED: Students and professionals from behavioral health, nursing, pharmacy, psychiatric nursing and social work.

OVERVIEW: This intervention project centers on interprofessional care to support approximately 80 adults with chronic pain. Many of the individuals in this patient cohort have not experienced regular preventive care, and so increasing access to preventive care is part of the intervention. Education about the health risks of opioids is also part of the project, and it is delivered via shared medical visits and a six-week course. Pre-intervention data about preventive care use were collected through the health system’s 2014 quality care indicators. Additionally, emergent nurse leaders will develop and demonstrate skills in interprofessional team building, collaborative problem solving, shared decision making models, and care coordination. Outcome measures associated with patients will include awareness of opioid medication risks, attendance at shared medical visits, prevalence of substance abuse disorders, medication adherence, medication refill histories, patient toxicology reports, and number of emergency department visits. Outcome measures for health professionals working on this project will include scores on the Assessment of Interprofessional Team Collaboration Scale.
Sheridan Health Services is a nonprofit, nurse-managed federally qualified health center. It operates a community health center and a school-based clinic. Special services include child and teen care, behavioral health, dental care, women’s health, and case management. Its board includes clinic users and consumers from the Sheridan community.

PROJECT STUDY QUESTION:
• For patients with chronic pain, what is the effect of team based care on increasing utilization of preventive healthcare?
INTERPROFESSIONAL COMMUNITY-ACADEMIC RESOURCE ENGAGEMENT (I-CARE) PEDIATRIC PREVENTIVE CARE

STATE: Colorado

MEMBER SINCE: December 2015

PARTNERS:
Sheridan Health Services, University of Colorado College of Nursing
University of Colorado School of Pharmacy
University of Colorado School of Dental Medicine
University of Denver Graduate School of Social Work
Metropolitan State University Dietetics Program
Colorado School of Public Health

OCCUPATIONS REPRESENTED: Students and professionals from diabetes education, dietetics, nursing, medicine, pharmacy, public health, psychiatric nursing and social work.

OVERVIEW: This intervention project takes place in Sheridan Health Services’ School Based Health Center. There are two patient cohorts for testing the impact interprofessional care teams. One cohort contains 80 pediatric patients with asthma, and the other contains 85 pediatric patients with a body mass index (BMI) at or above the 85th percentile. The care teams aim to increase the number of patients with controlled asthma and decrease the number of patients with high BMIs. They also plan to increase patients’ knowledge of healthy habits and access to preventive health care.

Outcome measures associated with asthma patients will include development pharmacological treatment plans, emergency room visits, albuterol usage, and spirometry. Outcome measures for the obesity-prevention patient cohort will include documented weight education, BMI, self-reported screen time and self-reported activity time.

For obesity prevention, patient satisfaction will be assessed through interviews with a sample of parents whose children are enrolled in a weight management program. Outcome measures for health professionals working on this project will include scores on the Assessment of Interprofessional Team Collaboration Scale.

Sheridan Health Services is a nonprofit, nurse-managed, federally qualified health center. It operates a community health center and a school-based clinic. Special services include child and teen care, behavioral health, dental care, women’s health, and case management. Its board includes clinic users and consumers from the Sheridan community.

PROJECT STUDY QUESTION:
• How does an interprofessional team-based approach to care and patient education affect uncontrolled asthma and increase prevalence of obesity in a pediatric patient population?
INTERPROFESSIONAL CARE COORDINATION TEAMS TO ADDRESS DIABETES

STATE: Illinois
MEMBER SINCE: January 2016

PARTNERS:
Loyola University Chicago Institute for Transformative Interprofessional Education
Loyola University Chicago Marcella Niehoff School of Nursing
Loyola University Chicago Stritch School of Medicine
Loyola University Chicago Medical Center

OCCUPATIONS REPRESENTED: Students and professionals including care coordinators, dietitians, nurse practitioners, nurse managers, physicians, psychologists, and social workers.

OVERVIEW: Loyola University received HRSA funds to develop nurse-led interprofessional teams in a family medicine clinic. This participatory action project involved all members of the clinic in the creation of a redesigned model of care delivery to improve patient outcomes for a moderate-high risk population of individuals with diabetes using the Patient-Centered Medical Home (PCMH) model of care delivery.

This project studies the impact of a nurse led; Interprofessional care coordination team on both outcomes for diabetic adult patients and outcomes for health care providers. Each of the three care teams is coordinated by a registered nurse and includes a nurse practitioner, physician, social worker, and a dietitian. When available, students of these professional roles also participate. Care teams will meet monthly as well as just prior to a patient’s visit. The pre-visit huddle clarifies plans for the day and ensures the care team has up to date information. Individual members of the care team may visit the patient at home. All members of the care team receive standardized instructions for their role within the team through video modules created at Loyola specifically for this project.

Patient outcome measures for this project include HgA1c levels, BMI, and rates of completed annual foot and eye exams. Patient engagement and satisfaction scores, provider satisfaction scores and costs of care will also be measured.

PROJECT STUDY QUESTION:
• What is the effect of health care delivered by an interprofessional care coordination team among adult diabetic patients.
THE MORAL DEVELOPMENT OF INTERPROFESSIONAL TEAM BASED CARE: A METACOGNITIVE, SOCIAL DETERMINANT MEMBERSince: November 2015

PARTNERS:
RFUMS DeWitt C. Baldwin Institute for Interprofessional Education
RFUMS Health Clinic: Interprofessional Community Clinic
RFUMS College of Health Professions
RFUMS College of Pharmacy
RFUMS College of Medicine
RFUMS Scholl College of Podiatric Medicine
DePaul University School of Nursing at RFUMS
RFUMS Simulation Laboratory

OCCUPATIONS REPRESENTED: Students and professionals from the following RFUMS programs: medicine, nursing, nurse anesthesia, pathology assistant, pharmacy, physical therapy, physician assistant, podiatric medicine, and psychology.

OVERVIEW: Our initiative focuses on the linkage between educational strategies and patient outcomes addressing the Triple Aim. The specific aim of the research program is to change student IP behaviors and improve patient outcomes through developing a hybrid simulation intervention utilizing the ethics and values competencies as defined by the Interprofessional Education Collaborative (IPEC) model and the social determinants of health derived from the community that we serve.

Three IP groups of health professional students will undergo intensive diagnostic reasoning activities designed to reflect the health and social determinant issues that a typical patient in the local area may experience. Debriefing will be done using metacognitive strategies. The students will be assessed by cognitive and behavioral measures pre and post intervention. The same groups of student will then be placed within a local diabetes education clinic over 12 weeks and be reassessed at the conclusion of the clinic. The patients will be tested pre and post intervention on BMI, A1C and Locus of Control measures to assess improvement. This study will be repeated over a 4 year time period to ascertain relationships between IPECP and patient outcomes.

North Chicago, the location of the study, is a designated Medically Underserved Area/Population (MUA/P). This population experiences high levels of obesity and diabetes which is intensified by social determinants of health such as education levels and poverty levels as well as food deserts. Related characteristics observed in the local patient community will be incorporated into the simulation model.
PROJECT STUDY QUESTION:
• For students in an Interprofessional (IP) class and in an IP clinic, does a moral development and ethical interprofessional simulation intervention positively affect IP team behavior?
• For patients being treated in an IP clinic, does being treated by students that received a moral development and ethical simulation positively affect select patient outcomes.
INTERPROFESSIONAL STUDENT TEAMS DEVELOP COMPREHENSIVE CARE PLANS

STATE: Indiana

MEMBER SINCE: March 2015

PARTNERS:
University of Southern Indiana (USI) College of Nursing and Health Professions (CNHP)
USI Community Health Centers at Glenwood, Cedar Hall, and Lodge
Marion Veterans Affairs Medical Center and Community Clinics in Evansville and Vincennes (IN) and Owensboro (KY)

OCCUPATIONS REPRESENTED: Students and professionals including dietitians, nurses, occupational therapists, occupational therapy assistants, respiratory therapists and social workers.

OVERVIEW: Students engage with the Veteran’s Administration (VA) Patient Aligned Care Teams (PACT), as well as nurse practitioners and support staff from the USI Community Health Centers, to develop comprehensive care plans and provide patient care. The teams are charged with developing a plan of care that addresses an individual's primary health care needs. Resources for the plan include individual, family and community assessments, and it is developed in collaboration with the IPE team, the individual and the family/support system. The teams also integrate technology such as telehealth to assist and support the patients for better self-management of their health. USI faculty members serve as Interprofessional Clinical Coaches (ICC) at each location. Intended intervention outcomes include improved management of chronic conditions and reduced hospital admissions.

The Marion VA Medical Center and its community-based outpatient clinics serve veterans in the tristate area of southwestern Indiana, southeastern Illinois and western Kentucky. The area is comprised of 35 counties that are predominantly rural, and 80% of the area is designated as a health professions shortage area (HPSA).

The USI Community Health Centers are located in schools with the Evansville Vanderburgh School Corporation. The health centers serve a racially diverse population in a designated health professions shortage area (HPSA). In 2014, the percentage of residents in this community with income below the poverty level was three times greater than the statewide percentage.

PROJECT STUDY QUESTION:
• In a primary care patient population, what is the effect of an interprofessional educational clinic model on pre-established patient level outcomes for hypertension, diabetes mellitus, depression and chronic obstructive pulmonary disease, compared to baseline data over a 28-month timeframe?
• In a health professional student population, what is the effect of an interprofessional educational clinical model on student-level measurements of team structure, leadership, situational monitoring, mutual support and communications, compared to baseline data over a 28-month timeframe?
• In health care professionals, what is the impact of a formal leadership program on leadership competency and management skills, compared to baseline data over a 12-month timeframe?
THE BLOOMINGTON NEXUS PROJECT: INTERPROFESSIONAL TEAM CARE NAVIGATION

STATE: Indiana

MEMBER SINCE: November 2015

PARTNERS:
Indiana University (IU) – Bloomington, Schools of Medicine and Nursing
Indiana University Health Bloomington Hospital

OCCUPATIONS REPRESENTED: Students and professionals including nurses and physicians

OVERVIEW: The Bloomington Nexus project creates a translational model for improving transitional care for patients who have been discharged from acute care. The primary goal of the project is to utilize interprofessional student navigation teams from Indiana University health professions schools to facilitate safe and effective transition across the continuum of care. Specifically, the navigation teams, who have already undergone TeamSTEPPS training and practice in simulation, will be making home visits on patients who were discharged after readmission. Student teams work with transitional care providers and faculty to facilitate safe passage for patients. The targeted learners are senior nursing students and 2nd year medical students.

Outcome measures studied for this project include readmissions, adherence to therapeutic regimens, missed doses of medication, process indicators such as appointment and referral records, patient satisfaction, and cost of care.

PROJECT STUDY QUESTION:

• In discharged acute care patients, what is the effect of student teams conducting a home discharge plan of care gap analysis on patient satisfaction, reduction in hospital readmission and reduction of care costs compared with similar patients not receiving discharge plan of care gap analysis within 12 months?
INDIANA UNIVERSITY HEALTH INTERPROFESSIONAL COLLABORATIVE PRACTICE MODEL

MEMBER SINCE: November 2015

STATE: Indiana

PARTNERS:
Indiana University-Purdue University Indianapolis (IUPUI) School of Nursing
Indiana University School of Medicine
Indiana University Health (IUH), Methodist Hospital

OCCUPATIONS REPRESENTED: Students and professionals including case manager, nurses, nurse practitioners, pharmacists, physical therapists, and physicians. Social work, physician assistants

OVERVIEW: The Accountable Care Unit (ACU) model encompasses unit-based clinical triads that consist of the RN, MD, and care manager, who use team-based care; relational coordination with shared goals, shared knowledge and mutual respect; unit-based leadership and management; patient centered workflow that incorporates daily clinical triad “huddles” on individual patient concerns, RN/MD collaborative rounding, safe handoffs; and data-driven unit-based decision making. The team uses lean processes, innovation, and the synergy of collaborative clinical leadership to increase care efficiency, quality and improved care transitions. Other professions engaged with the clinical triads on an intermittent basis. Measurement tools used for this project include the Safety Organizing Scale (SOS), Collaboration and Satisfaction About Care Decisions (CADCS), and the HCHAPS patient satisfaction tool. Additional outcomes measured for this project include length of stay, readmission rates, falls per month, and incidence of pressure ulcers, blood stream infections and urinary tract infections.

PROJECT STUDY QUESTION:
• On four units within IUH Methodist Hospital, what is the effect of use of the ACU model of care delivery on patient satisfaction, provider satisfaction, patient care outcome indicators, and cost over a three year period
KNOWLEDGE ABOUT ROLES IMPARTED DURING MORNING HUDDLE; KNOWLEDGE TOOL; INTERPROFESSIONAL SCREENING TEAM

STATE: Indiana

MEMBER SINCE: November 2015

PARTNERS:
Indiana University Indianapolis Student Outreach Clinic
Indiana University Schools of Medicine, Optometry, and Public Health
Indiana University Purdue University Indianapolis Schools of Dentistry, Health and Rehabilitation Sciences, Nursing, Fairbanks School of Public Health, and Social Work
Indiana University University Physical Therapy and Occupational Therapy programs
Indiana University Health Physicians
Near East neighborhood, Indianapolis IN

OCCUPATIONS REPRESENTED: Dentistry, Law, Medicine, Nursing, Occupational Therapy, Physical Therapy, Public Health, and Social Work

OVERVIEW: Leaders have identified a need to enhance knowledge about roles, scope of practice, and training of professions at the clinic. Leaders are concerned that lack of knowledge is reducing interprofessional collaboration and contributing to inappropriate, over-, or under-utilization of services.

The main objective of this project is to improve quality of care, increase interprofessional collaboration, and increase efficiency in utilization of resources by: 1) increasing knowledge about roles, scope of practice, and training of the professions at the clinic and 2) assembling an interprofessional team to screen patients on admission to the clinic and make recommendations for collaboration across professions.

Outcome measures studied for this project include change in self-reported ability to work with others, value in working with others, and comfort working with others; knowledge about professional roles, scope of practice, and training; number and nature of interprofessional collaboration and referral requests between services for patients pre- and post-intervention.

PROJECT STUDY QUESTION:
• How will the intervention of Education provided during morning huddle, a Knowledge Tool, and integration of an Interprofessional Screening Team into the clinic impact subscale scores in students’ self-reported ability to work with others, value in working with others, and comfort working with others, knowledge about professions, the number of requests for interprofessional collaborations, and the percentage of appropriate referrals between services at the IUSOC?
DEVELOPING PRECEPTORS FOR INTERPROFESSIONAL PRACTICE AND EDUCATION

STATE: Kansas
MEMBER SINCE: December 2014

PARTNERS:
University of Kansas Medical Center (KUMC) Interprofessional Teaching Clinic (IPTC)
Three rural primary care clinics

OCCUPATIONS REPRESENTED: Students and professionals including clinical psychologists, health information managers, lawyers, nurses, occupational therapists, pharmacists, physical therapists, and physicians.

OVERVIEW: In an effort to enhance primary care delivery, this intervention develops an interprofessional practice and education (IPE) curriculum for preceptors who are jointly affiliated with both health care education and clinical practice. The preceptor is the learner first, then they develop an interprofessional learning IN practice experience for learners at their site to apply their newly acquired knowledge, attitudes, and behaviors.

The educational objectives of the interprofessional preceptor development curriculum include understanding interprofessional collaboration, improving interprofessional facilitation skills, changing practice/precepting behavior, enhancing team-based care and including interprofessional learners in practice, modifying perceptions about team care, building knowledge and skills for team care and introducing the benefits of team care to service delivery. The preceptor development curriculum was created locally for the prototypical interprofessional learning IN practice model and refined for a national audience.

A packaged preceptor development toolkit has been developed that includes online learning modules, preceptor development active-learning materials, and interprofessional educational curricular materials to be used to enhance the practice-based experience for learners. Within the prototypical interprofessional learning IN practice model at KUMC, preceptors have undergone this development and the model has been sustained for five years. Patient impact is measured by tracking patient health and overall patient satisfaction.

Three additional rural clinics agreed to transforming to an interprofessional learning IN practice model within the last year. Materials from the preceptor development toolkit were used and then the interprofessional learners were integrated into the practice. The impact on learners and preceptors are being measured.

PROJECT STUDY QUESTION:
• What is the effect of an interprofessional preceptor development program on preceptor and learner satisfaction, attitudes, knowledge, skills and behavior?
• What is the impact of an interprofessional teaching clinic on patient outcomes?
INTERPROFESSIONAL CARE ACROSS TRANSITIONS FOR STROKE PATIENTS

STATE: Kentucky
MEMBER SINCE: April 2014

PARTNERS:
University of Kentucky (UK)
Cardinal Hill Rehabilitation Hospital
Home health and outpatient agencies

OCCUPATIONS REPRESENTED: Students and professionals including physical therapy, occupational therapy, speech and language pathology, dietary, nursing, pharmacy, psychology, medicine, case management, and social workers.

OVERVIEW: The simulation phase will demonstrate the importance of interprofessional collaborative practice and guide providers and students on how to become effective team members. Providers from both acute care and acute rehabilitation will work together to create and test the interprofessional transition of care tool (KCATS tool). This tool will then be piloted in care transitions across levels of care including:
• Acute care to post-acute care
• Post-acute care to community
• Acute care to community
Outcome measures will include assessment of the simulation itself, interprofessional collaboration using the interprofessional collaborator assessment rubric, and clinical and patient outcomes. In addition hospital and clinical data will be monitored after implementation of the KCATS tool to include: tracking length of stay, functional independence, complications and medical errors, readmissions, patient and provider satisfaction, and cost of care.

PROJECT STUDY QUESTION:
• What is the effect of an interprofessional team-based transition of care tool on outcomes for patients with stroke?
IMPLEMENTING A CLINICAL INTERPROFESSIONAL CURRICULUM BASED ON PATIENT CENTERED MEDICAL HOME STANDARDS AND INTEGRATING IPEC COMPETENCIES IN A PRIMARY CARE SETTING

STATE: Maine

MEMBER SINCE: February 2016

PARTNERS:
University of New England’s Center of Excellence in Health Innovation, in collaboration with UNE partners of: College of Dental Medicine, College of Osteopathic Medicine, College of Pharmacy, campus-based faculty-led Interprofessional Education Collaborative, and Westbrook College of Health Professions
Eastern Maine Medical Center and Penobscot Community Health Care

OCCUPATIONS REPRESENTED: Students and professionals from osteopathic medicine, physician assistants, and pharmacy, along with dental medicine, social work, and public health.

OVERVIEW: In order to implement IPE in the clinical practice setting, this intervention incorporates UNE’s Clinical Interprofessional Curriculum (CIPC), which can be found at: http://www.une.edu/clinical-interprofessional-curriculum. CIPC is based on the NCQA patient-centered medical home (PCMH) recognition standards, such as those involving a comprehensive visit and assessment with a complex patient, as well as quality improvement and population health standards. The learning activities also infuse the IPEC competencies and reinforce the use of TeamSTEPPS skills. While helping students to achieve interprofessional competencies, the CIPC is also meant to assist the practice in achieving the PCMH standards. UNE students are also provided robust on-campus IPE during their pre-clinical training years, including: interprofessional seminars; joint curricula between, for instance, dental medicine and osteopathic medicine; interprofessional simulations; and interprofessional service learning.
OVERVIEW (cont.): The University of New England confers 13 health degrees including osteopathic medicine, pharmacy, dental medicine, nursing, physician assistant, social work, dental hygiene, nurse anesthesia, occupational therapy, physical therapy, public health, applied exercise science, and athletic training. UNE has a 15-year history of developing and implementing campus-based IPE. UNE is entering its 5th year of developing and implementing clinical IPE with some of its clinical partners, and is expanding from medicine and pharmacy students conducting comprehensive patient visits to including students from other professions as well as other learning activities such as those focused on quality improvement and population health.

Eastern Main Medical Center (EMMC) is one of 12 UNE clinical campuses hosting osteopathic medical students for their third year clinical core rotations. This includes a 6-week family practice rotation in the Family Medicine Center. University of New England (UNE) students from pharmacy and other professions train there as well. As UNE’s largest clinical affiliate and a participant in several UNE IPE trainings, EMMC’s Medical Education Department launched an interprofessional home visiting program, with medical and pharmacy students visiting complex patients who are recently discharged from the hospital. They are expanding interprofessional patient encounters to other venues.

Penobscot Community Health Care (PCHC) is Maine’s largest Federally Qualified Health Center (FQHC) and only teaching health center, with 16 clinical sites that stretch across the breadth of the state from Jackman (in the northwest near the Canadian border) to Belfast (Downeast). UNE medical students based at EMMC doing a 4-week community health rotation at PCHC as well as UNE pharmacy, physician assistant, and dental medicine students (and we hope to add social work) participate in IPE at PCHC, implementing the CIPC.

Outcome measures include teamness assessments and Consumer Assessment of Healthcare Providers and Systems (CAHPS) scores, as well as specific patient outcomes associated with diabetes, cardiovascular disease, depression, obesity, asthma and COPD, and potentially chronic pain. An interprofessional facilitation tool may also be used.

PROJECT STUDY QUESTION:
• What is the impact of interprofessional team-based curricula on student learning, clinical practice, patient outcomes, and cost?
IPE TO IMPROVE DIABETES HEALTH OUTCOMES

STATE: Michigan
MEMBER SINCE: April 2014

PARTNERS:
Grand Valley State University (GVSU) College of Health Professions
Ferris State University (FSU) College of Pharmacy
Michigan State University (MSU) College of Human Medicine
Cherry Health - Cherry Street Health Center

OCCUPATIONS REPRESENTED: Students and professionals including clinical site managers, dietitians, medical assistants, nurses, patient registration coordinators, pharmacists and physicians.

OVERVIEW: A student team of medical, physician assistant and pharmacy students are working with health care providers at Cherry Street Health Center, a non-profit Federally Qualified Health Center (FQHC), to provide collaborative care during clinical appointments and through daily huddles, case conferences, patient call backs and patient education classes about diabetes. The students and professionals involved have completed online training* for interprofessional collaboration.

Among approximately 250 diabetic adults, the intervention is studying health outcomes by tracking measures, such as hemoglobin A1c, BMI and LDL, and adherence to annual eye, foot and dental appointments.

*The online training was developed by the Midwest Interprofessional Practice, Education, and Research Center (MIPERC). The initiative identifies how GVSU, FSU, MSU and Grand Rapids Medical Education Partners, as well as other regional partners, can develop collaborative, innovative and interprofessional initiatives across disciplines, learning institutions and health care systems.

PROJECT STUDY QUESTION:
• Does an interprofessional collaborative practice model improve health outcomes and patient satisfaction among adults with diabetes? And does it improve provider satisfaction?
EMERGING ROLE ON THE INTERPROFESSIONAL TEAM: MEDICAL SCRIBES IN THE EMERGENCY DEPARTMENT

STATE: Michigan
MEMBER SINCE: April 2014

PARTNERS:
Grand Valley State University (GVSU)
Emergency Care Specialists, P.C. (ECS)

OCCUPATIONS REPRESENTED: Students and professionals including HIM professionals, medical coders and billers, medical scribes, nurse assistants, nurse practitioners, patient registration professionals, pharmacists, physicians, physicians assistants and registered nurses.

OVERVIEW: This collaborative intervention project places students from the Grand Valley State University Scribe Academy on provider teams at emergency departments in western Michigan. The purpose is to study whether adding medical scribes can increase efficiency in the emergency departments and increase satisfaction for patients. Medical Scribes will be assigned to specific providers and focus on documentation of care, identification of key data for care, and document clarification as needed.

The Scribe Academy is taught by GVSU and ECS employees focusing on theoretical and clinical components. Topics include medical billing and coding, health information management, pathophysiology of body systems, diagnostics, common medications, medical terminology and electronic medical record systems. Specific competencies will be measured through testing, surveys, focus groups, and observer evaluations.

Outcome measures include provider efficiency measures such as daily rates for charts completed, patients seen per hour, and number of provider overtime hours paid. Patient satisfaction scores will also be captured. Comparison data will be collected from emergency departments without medical scribes.

PROJECT STUDY QUESTION:
• In emergency rooms, what is the effect of using medical scribes on provider efficiencies and workflow?
OPTIMIZING TRIPLE AIM OUTCOMES UTILIZING IPECP FOR DENTISTRY AND PHARMACY

STATE: Minnesota

MEMBER SINCE: March 2014

PARTNERS:
University of Minnesota College of Pharmacy
University of Minnesota School of Dentistry Clinics

OCCUPATIONS REPRESENTED: Students and professionals from dental hygiene, dental therapy, dentistry and pharmacy.

OVERVIEW: This project is focused on interprofessional education and collaborative practice between pharmacists and oral health professionals by adding medication therapy management services to existing general dentistry practice. Pharmacists participate on the dental teams at the School of Dentistry Clinics to evaluate and care for adult patients with chronic conditions. The team performs assessments of the patient including oral health needs and identifies general health and medication issues. Team members also communicate with other primary care providers and refer when indicated. A multidisciplinary care plan is developed, and patients seen by the team are tracked to measure health outcomes. Case conferences are held regularly to discuss relevant issues. The School of Dentistry Clinics provide important oral health resources to under-represented urban and rural patient populations. The Clinics also provide interprofessional teaching and learning opportunities for faculty and students. Measures for this project include blood pressure, diabetes monitoring, tobacco use history and cessation, vaccinations, and scores on the Oral Health Impact Profile.

PROJECT STUDY QUESTION:
• In adult patients who are seeking care in a dental school setting, what is the effect of a Interprofessional collaborative dental/pharmacy practice model on selected primary care outcomes and quality of life compared with a matched cohort of patients?
• In dental and pharmacy providers and dental student providers, what is the effect of a collaborative dental/pharmacy practice model on interprofessional knowledge gains and conception of their role as a primary care clinicians compared with a matched cohort of dental and pharmacy providers and dental and pharmacy students?
ACHIEVING HEALTHY CHILDREN WITH COLLABORATIVE CARE

STATE: Minnesota
MEMBER SINCE: March 2014

PARTNERS:
University of Minnesota Community-University Health Care Center (CUHCC)
University of Minnesota Academic Health Center
Community service agencies

OCCUPATIONS REPRESENTED: Learners and professionals including case managers, a dental therapist, integrated care managers, medical assistants, medical doctors, mental health professionals (psychiatry and therapy), nurse care coordinators, nurse practitioners, and pharmacists.

OVERVIEW: CUHCC, a Federally Qualified Health Center (FQHC), serves a complex and diverse patient population with a majority of families living below the federal poverty level. This intervention observes the impact of a SOAR visioning process, TeamSTEPPS training, and equity and diversity training for its staff on outcomes associated with pediatric measures including immunizations, well-child check-ups, weight screening, preventive dental visits, mental health functioning, patient satisfaction and cost of care.

A population of patients aged 0-17, who have had two medical and two mental health visits within a year, are included in the intervention. The study specifically measures changes in care delivery and receipt of preventive care.

PROJECT STUDY QUESTION:
• How does an interprofessional care delivery model and educational program that builds the capacity of its workforce lead to improved outcomes for children?
ENHANCING THE PRIMARY CARE CLINIC TEAM

STATE: Minnesota

MEMBER SINCE: March 2014

PARTNERS:
University of Minnesota Department of Family Medicine and Community Health (DFMCH)
University of Minnesota College of Pharmacy
University of Minnesota Medical School
University of Minnesota Physicians

OCCUPATIONS REPRESENTED: Students and professionals including care coordinators, case managers, interpreters, lab technicians, licensed practical nurses, medical assistants, medical residents, medical students, nurses, nurse practitioners, patient service representatives, pharmacists, physicians, physician assistants, social workers and ultrasound technicians.

OVERVIEW: DFMCH is testing transformative standardized teamwork using an interprofessional practice and education (IPE) approach that includes the patient in the learning, practice and outcome model. DFMCH manages primary care residency clinics that are building a new model of team-based care using an expansion of the certified medical assistant (MA) role. The intervention places MAs as "visit assistants" working closely, in a non-duplicative manner, with the primary care clinician during all primary care visits. The model coordinates behavioral and medical approaches to care delivery, and the goal is to develop a successful model that is both transportable and scalable. Outcomes measured in the study include specific health outcomes associated with diabetes and other chronic diseases, team competencies, patient and provider satisfaction, wait times, and care process completions.

PROJECT STUDY QUESTION:
• How does care provided by an enhanced interprofessional team impact certain disease outcomes as well as the delivery of preventive care?
MINDFULNESS AND WELLBEING FOR THE MATURE WOMAN

STATE: Minnesota
MEMBER SINCE: March 2014

PARTNERS:
University of Minnesota Women’s Health Specialists Clinic

OCCUPATIONS REPRESENTED: Students and professionals including acupuncturists, health coaches, nurse practitioners, physicians, psychologists and Reiki therapists.

OVERVIEW: The Women’s Health Specialist clinic has developed a six-week course about health and wellness in the context of menopause. This interprofessional health education program seeks to improve a woman’s mid-life health by increasing adherence to prevention guidelines, increasing effective utilization of self-care strategies and planning for future health needs associated with aging. The course is led by a health coach, and the presenters include an interprofessional care team from the clinic.

PROJECT STUDY QUESTION:
• What is the impact of an interprofessional team on educating and supporting women experiencing menopause?
CLINICAL PRACTICUM: PREPARING UNDERGRADUATE SENIOR HEALTH PROFESSIONS STUDENTS TO BE COLLABORATION READY IN CLINICAL SETTINGS

STATE: Missouri

MEMBER SINCE: July 2016

PARTNERS:
- Saint Louis University Center for Interprofessional Education and Research
- Saint Louis University School of Nursing
- Saint Louis University Doisy College of Health Sciences
- 20 clinical sites in the St. Louis metro area

OCCUPATIONS REPRESENTED: Students and professionals from nursing, physical therapy, athletic training, occupational therapy, magnetic resonance imaging, radiation therapeutics, nuclear medicine technology, nutrition and dietetics, and pre-medical students.

OVERVIEW: This practicum gives students the opportunity to integrate classroom learning into clinical settings, working directly on using team approaches to improve patient outcomes. During the semester-long course, students participate in two separate 4-week clinical placements. They have the opportunity to interview providers, staff, patients and caregivers about experiences with team-based care. Twenty clinical sites participate, including hospitals, healthcare organizations, and community-based services in the St. Louis metro area. These sites utilize interprofessional teams to provide individual patient care. Students gain experience in how different interprofessional teams function as well as the environmental and personal attributes that contribute to effective teams and improved patient outcomes. Student outcome data are collected from project workplans, critical reflections, and a pre/post self assessments. Agency satisfaction is captured using a custom survey instrument.

PROJECT STUDY QUESTION:
- Does a team-based clinical practicum experience improve students’ skills and competencies in interprofessional collaboration to provide individual patient care?
GRADUATE IP TEAM SEMINARS: PREPARING HEALTH PROFESSIONS STUDENTS AS COLLABORATION READY TEAM MEMBERS TO IMPROVE INDIVIDUAL PATIENT OUTCOMES AND SAFETY

STATE: Missouri

MEMBER SINCE: July 2016

PARTNERS:
Saint Louis University Center for Interprofessional Education and Research
Saint Louis University School of Medicine
Saint Louis University School of Nursing
Saint Louis University Doisy College of Health Sciences
Saint Louis University College for Public Health and Social Justice
Saint Louis College of Pharmacy

OCCUPATIONS REPRESENTED: Students and professionals from medicine, nursing, physical therapy, occupational therapy, physician assistant, social work, and pharmacy.

OVERVIEW: This course has been an embedded component for seven health professions programs since 2009. It meets six times of the course of one academic year. The focus is interprofessional teamwork to improve patient safety and quality of care. It develops individual professional skills and teamwork skills while exploring effective systems and processes of care. Patient case reviews and reflection assignments are used to develop competencies in clinical teamwork that positively impact patient outcomes. Case reviews emphasize shared decision making models and interprofessional teamwork. Course readings describe process that contribute to or inhibit quality care and patient safety. Course activities offer opportunities to practice team skills and shared decision making processes.

Student outcomes are measured using pre/post course participation assessments that look at definitions of teamwork, knowledge of team communication techniques, and knowledge about how teamwork impacts patient outcomes. Student reflections capture information about attitudes, understanding patient-centered care, and abilities to implement new competencies.

PROJECT STUDY QUESTION:
• Compared to pre-course assessments, does participation in this team seminar improve students’ ability to identify and describe attributes and behaviors of effective interprofessional collaborative practice in clinical settings?
• How does participation in this IPE seminar improve students’ ability to identify and describe attributes and behaviors of effective interprofessional collaborative practice in clinical settings? Does the student narrative indicate transformational learning that may be correlated to future practice?
UNDERGRADUATE COMMUNITY PRACTICUM: PREPARING HEALTH PROFESSIONS STUDENTS AS COLLABORATION READY TEAM MEMBERS TO IMPROVE COMMUNITY AND POPULATION HEALTH

STATE: Missouri

MEMBER SINCE: July 2016

PARTNERS:
Saint Louis University Center for Interprofessional Education and Research
Saint Louis University School of Nursing
Saint Louis University Doisy College of Health Sciences
25 community-based agencies and partners in the St. Louis metro area

OCCUPATIONS REPRESENTED: Students and professionals from nursing, physical therapy, athletic training, occupational therapy, magnetic resonance imaging, radiation therapeutics, nuclear medicine technology, nutrition and dietetics, and pre-medical students.

OVERVIEW: This practicum course places approximately 30 teams of students representing nursing, physical therapy, athletic training, occupational therapy, magnetic resonance imaging, radiation therapeutics, nuclear medicine technology, nutrition and dietetics, and pre-medical students with community-based agencies. These agencies target medically under-served and/or disadvantaged populations, and examples include Red Cross, the American Diabetes Association, St. Louis Area Agency on Aging, and the St. Louis Asthma and Allergy Foundation. Each team contains 5 students and supports or implements a project that furthers the mission of its assigned agency. Students build skills in project development and implementation and learn how agency services support promotion of health and wellness. St. Louis University offers a concentration and a minor in Interprofessional Practice, and this practicum is part of both programs. Student outcomes include increased ability to recognize and define population health needs. Data are collected from project workplans, critical reflections, and a pre/post Team Fitness Test. Agency satisfaction is captured using a custom survey instrument.

PROJECT STUDY QUESTION:
• Does a community-based practicum experience improve students’ skills and competencies in interprofessional in community settings and for addressing population health?
THE INTERPROFESSIONAL EDUCATION PASSPORT

STATE: Nebraska
MEMBER SINCE: March 2016

PARTNERS:
Creighton University (CU) College of Nursing
CU School of Dentistry
CU School of Medicine
CU School of Pharmacy and Health Professions
CHI Creighton Ambulatory Care Center

OCCUPATIONS REPRESENTED: Students and faculty from dentistry, emergency medical services, medicine, nursing, occupational therapy, pharmacy, and physical therapy.

OVERVIEW: This project develops an interprofessional curriculum named the IPE Passport. Approximately 600 students from seven health professions programs at Creighton University will complete IPE 400 Introduction to Collaborative Care (.5 credits) followed by three pre-approved IPE activities that comprise the Passport. The IPE activities will take place in coordination with CHI Creighton Ambulatory Care Center. The intent of the project is to train health professions students to be collaboration ready, allowing them to enter the workforce prepared to provide care via interprofessional teams. The curriculum facilitates students’ thinking about how individual providers and the health care system can improve care for vulnerable populations. Outcome measures for this project include scores on the Teams Skills Scale (TSS) and the Readiness for Interprofessional Learning Scale (RIPLS). Qualitative analysis will be based on students’ written reflections to questions about the value of collaborative care, interprofessional readiness, challenges and skills needed for successful interprofessional practice.

PROJECT STUDY QUESTION:
• Among students in seven health profession programs, what is the effect of IPE curriculum on learning and readiness to work on interprofessional teams?
PREPARING FAMILY NURSE PRACTITIONERS AND PHYSICIANS FOR INTERPROFESSIONAL COLLABORATIVE CARE WITH IPEC CORE COMPETENCIES

STATE: New York
MEMBER SINCE: February 2016

PARTNERS:
University of Rochester Department of Family Medicine, School of Nursing
University of Rochester Medical Center’s Center for Experiential Learning
Saint John Fisher College Wegmans School of Pharmacy
Highland Family Medicine

OCCUPATIONS REPRESENTED: Students and professionals including family medicine physicians, licensed practical nurses, marriage and family therapists, medical assistants, medical secretaries, nurses, nurse practitioners, pharmacists, psychologists, and social workers.

OVERVIEW: This project focuses on developing IPE competencies among nurse practitioners in a one-year residency program and family medicine residents in a three-year residency program. The intervention places the NP residents in weekly interprofessional education sessions with family medicine residents and on interprofessional collaborative care teams at Highland Family Medicine. The NP residents will have both NP and MD faculty preceptors, who will provide feedback on interprofessional skills development and teamwork. Outcome measures address evidence of teamwork and the IPE Core Competencies (Values/Ethics, Roles/Responsibilities, Interprofessional Communication and Teams/Teamwork). Scales to support measurement will include the IPEC Competency Survey Instrument and Assessment for Collaborative Environments tool (ACE-15). Changes in knowledge regarding communication, team roles, and health care policy will also be measured.

Highland Family Medicine provides the full spectrum of family medicine services to 20,000 patients, averaging 60,000 visits annually. The patient population is racially and ethnically diverse with over 60 different primary languages represented. Fifty percent of patients are Medicaid eligible. Additional onsite resources include behavioral health services, immunization outreach workers, chronic disease nurse case managers, a depression care manager, a blood pressure advocate, a Family Planning team, a social worker, an OB-GYN and a family physician with Sports Medicine training.

PROJECT STUDY QUESTION:
• How does an interprofessional education residency centered on the IPEC Competencies affect nurse practitioners’ and family medicine residents’ knowledge, skills, and attitudes compared to those of nurse practitioners who start working in primary care without the residency?
ASSESSING & ENHANCING CLINICAL EDUCATION SITES FOR IPECP

STATE: Oregon
MEMBER SINCE: July 2014

PARTNERS:
Oregon Health & Science University (OHSU)
OHSU Collaborative Life Sciences and Interprofessional Simulation Center
OHSU affiliated hospitals and clinics statewide
VA Portland Health Care System (VAPORHCS)

OCCUPATIONS REPRESENTED: Students and professionals including dentists, nurses and physicians.

OVERVIEW: Assessing and Enhancing Clinical Education Sites for IPE, or ACE intervention, is focused on placing learners in clinical education sites where teams with high levels of “teamness” model interprofessional collaborative practice. This intervention enhances the interface between education and clinical practice - also known as the Nexus - by focusing on educating learners in clinical settings where optimal teamwork skills are modeled. To determine which clinical settings offer this high-value learning, the intervention is broken into phases:
• Phase I establishes the validity and reliability of a method to assess interprofessional team work skills.
• Phase II consists of inviting clinical education sites to use ACE for internal team development. Semi-structured interviews will be used to gather process and outcome information about how sites use ACE and what kind of team development is achieved.
• Phase III will ask sites to engage in more extensive development and will collaborate with the ACE team to create site-specific programs to further enhance role models of collaborative practice for IPE learners.

Enhancing clinical education environments holds promise for a graduate’s ability to influence the Triple Aim by learning from high-performing teams that effectively deliver collaborative care.

PROJECT STUDY QUESTION:
• Assessing a clinical team's readiness for IPE
• Using assessments as an invitation for team development.
ELECTRONIC HEALTH RECORDS ENHANCE COLLABORATIVE CARE AND PATIENT OUTCOMES

STATE: Oregon

MEMBER SINCE: July 2014

PARTNERS:
Oregon Health & Science University (OHSU)
OHSU Collaborative Life Sciences and Interprofessional Simulation Center
OHSU affiliated hospitals and clinics statewide

OCCUPATIONS REPRESENTED: Students and professionals including nurses, pharmacists, physicians and respiratory therapists.

OVERVIEW: The focus of this intervention study is to improve, expand and standardize provider and student knowledge and use of an electronic health record (EHR) on both the individual and system level.

Using the Interprofessional Simulation Center, this intervention is creating a patient-centered, virtual environment using EHRs that develop study cases and an EHR “toolbox” for interactive team activities with faculty care teams that have student learners.

These cases are derived from a previous error study conducted in the medical intensive care unit (MICU). The intervention team has selected cases in which the errors likely resulted from confusion about particular EHRs and what information was used by the various providers.

Once the simulation identifies best practices that reduce these kinds of errors, the resulting standardized approach for entry and retrieval of patient information will be implemented on the MICU. Quantitative and qualitative outcome measures are used to capture the impact on up to 45 interprofessional care teams.

PROJECT STUDY QUESTION:
• What is the effect of the EHR on team decision making, error recognition and interprofessional communication?
INTERPROFESSIONAL CARE ACCESS NETWORK (I-CAN)

STATE: Oregon

MEMBER SINCE: July 2014

PARTNERS:
Oregon Health & Science University (OHSU) Schools of Dentistry, Medicine, and Nursing, and the OHSU/Oregon State University College of Pharmacy
OHSU Richmond Clinic
Billi Odegaard Dental Clinic
Maybelle Center for Community
Neighborhood House
Home Forward
La Clinica
Southern Oregon Head Start
Family Nurturing Center
Lutheran Community Services NW
Asian Health and Service Center
Russell Street Dental Clinic
Multnomah County Health Department’s Mid-County Health Center
Klamath Open Door
Sky Lakes Outpatient Care Management
Cascade Health Alliance (Coordinated Care Organization [CCO])

OCCUPATIONS REPRESENTED: Students and professionals including case managers, community health workers, dentists, dental hygienists, dietitians, drug and alcohol counselors, mental health professionals, nutritionists, nurses, nurse practitioners, pharmacists, physicians, physician assistants, psychologists, public health professionals, and social workers.
OVERVIEW: The Interprofessional Care Access Network (I-CAN) is a community-based interprofessional health care delivery and education program that addresses Triple Aim outcomes for vulnerable populations in urban neighborhoods and rural communities. The purpose of I-CAN is to establish an evidence-based model of care delivery demonstrating the impact of interventions focusing on social determinants of health. Goals are achieved through community-based partnerships and development of a healthcare workforce prepared for competent practice in emerging models of care. As a robust clinical model for interprofessional education, I-CAN teaches collaboration and accountability within a population health context. The continuity of a community-based nurse faculty-in-residence provides for sustained engagement with clients over multiple terms with rotating students, and long-term engagement results in sustainable changes in health behaviors among participating clients, committed community partnerships, and expansion of neighborhood resources. I-CAN provides care coordination for individuals and families with two or more non-acute EMS calls or missed medical appointments in six months; lack of a primary care home; lack of health insurance; elders and families lacking stable housing; and children with family members with a disabling chronic illness or developmentally delayed parent(s). The common factor among I-CAN clients and families is that they are poor and have significant barriers to achieving health; many are socially isolated. Clients are often resistant to traditional approaches to health care or have distrust or lack of understanding of the healthcare system. Interprofessional student teams visit clients weekly to address barriers to engagement in health care. Outcomes measured include housing status, health insurance, access to and use of primary care, food security, health literacy, emergency department visits, EMS calls and hospitalizations.

PROJECT STUDY QUESTION:
• What is the effect of the I-CAN model on patient satisfaction, cost, and population health outcomes among vulnerable populations?
QUALITY IMPROVEMENT AND LEADERSHIP DEVELOPMENT FOR RESIDENTS LEADING IP TEAMS

STATE: Pennsylvania
MEMBER SINCE: June 2016

PARTNERS:
Thomas Jefferson University and Jefferson Health
Sidney Kimmel Medical College at Thomas Jefferson University
Jefferson Family Medicine Associates (JFMA)
Jefferson Internal Medicine Associates (JIMA)

OCCUPATIONS REPRESENTED: Medical students, Physician Assistant students, Family Medicine and Internal Medicine residents and attendings, Nurse Practitioners and Medical Assistants

OVERVIEW: This project is centered on the development of a toolkit that will build skills among medical residents leading interprofessional teams and conducting quality improvement projects. The toolkit will contain modules for leadership development and focus on skills that support planning, implementation and evaluation of interprofessional quality improvement projects. These could include population health assessments, rapid-cycle quality improvement, root-cause analysis, safety interventions, engagement of new community partners, or interventions targeting specific health outcomes. The initial phase of this project will pilot the toolkit among a small number of residents. The final product will be made available to all residents at JFMA and JIMA for use in developing quality improvement projects. Health professions students participate on the teams in this project.

The measures for this project include a leadership efficacy scale, as well as changes in attitudes and skills associated with project management and implementation. In addition, the Jefferson Teamwork Observation Guide will be used to evaluate team function, and Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey will be used to measure changes in patient satisfaction.

Jefferson Family Medicine Associates and Jefferson Internal Medicine Associates are two primary care medical homes that serve a racially and economically diverse area of Philadelphia.

PROJECT STUDY QUESTION:
• For two primary care clinics, can a quality improvement toolkit increase interprofessional team leadership and project management skills for residents serving as team leaders?
• Does the toolkit improve the quality and relevance of system improvement projects completed by resident-led IPE teams?
NON-PHYSICIAN LED, INTERPROFESSIONAL TEAMS IN A TRAUMA CLINIC

STATE: Pennsylvania
MEMBER SINCE: March 2014

PARTNERS:
University of Pittsburgh Medical Center (UPMC) Falk Trauma Clinic
UPMC Office of Advanced Practice Providers
UPMC Donald D. Wolff, Jr. Center for Quality, Safety and Innovation
University of Pittsburgh School of Health and Rehabilitation Sciences

OCCUPATIONS REPRESENTED: Students and professionals including audiologists, nurse practitioners, nutritional counselors, occupational therapists, physician assistants, physical therapists, rehabilitation counselors and speech and language pathologists.

OVERVIEW: Advanced practice providers (APPs) are joined by licensed professionals and students from physical therapy, occupational therapy, speech language pathology, audiology, nutritional counseling and rehabilitation counseling to develop comprehensive care plans and provide patient care.

The UPMC Falk Trauma Clinic utilizes an APP-led team of clinicians, involving a range of rehabilitative medicine practitioners, to provide patient evaluation and transition of care services for trauma patients discharged from UPMC Presbyterian Hospital. Responding to a population health need for additional post-discharge musculoskeletal care, this clinic customizes the care experience to provide patient-centered, multidisciplinary clinical management.

For each patient seen, a nurse coordinator develops a tentatively tailored evaluation plan, which is then formalized with the interprofessional team. Patients are seen sequentially by members of the tailored team. Communication between team members is facilitated by an Interprofessional Clinic Evaluation Flow Sheet, with all clinical recommendations ultimately funneled to the APP.

PROJECT STUDY QUESTION:
• What are barriers and facilitators influencing process redesign and the successful implementation of interprofessional teams?
• How does the interprofessional team impact appropriateness and quality of care?
• Is this a sustainable model in the context of the rapidly changing health care marketplace?
TEAM TRAINING TO IMPROVE QUALITY AND SAFETY OUTCOMES IN THE CLINICAL SETTING

STATE: South Carolina

MEMBER SINCE: March 2014

PARTNERS:
Medical University of South Carolina (MUSC)
Medical University Hospital

OCCUPATIONS REPRESENTED: Students and professionals including nurses, nurse practitioners, pharmacists, physical therapists, physicians and physician assistants.

OVERVIEW: This collaborative intervention evaluates how team training for student learners and clinicians improves quality and safety outcomes in the clinical setting. Students enrolled in an interprofessional elective course are trained and certified as TeamSTEPPS raters. The practicum of the course involves live, real-time evaluation of teamwork amongst all faculty and staff working in the OBGYN unit of the hospital before and after the faculty and staff all undergo TeamSTEPPS training. TeamSTEPPS ratings are collected by students for all work shifts and faculty/staff member interactions on the OBGYN unit during the weeks of observation. In addition to studying teamwork scores and patient satisfaction, this intervention also looks at measures associated with medical errors and surgical site infection rates.

PROJECT STUDY QUESTION:
• What is the effect of TeamSTEPPS training on teamwork-behaviors compared with pre-TeamSTEPPS teamwork-behaviors over a 12-month time frame?
PROMOTING QUALITY CONVERSATIONS ABOUT ADVANCE CARE PLANNING IN SOUTH DAKOTA THROUGH INTERPROFESSIONAL TEAMS

STATE: South Dakota

MEMBER SINCE: June 2015

PARTNERS:
University of South Dakota
Peace Lutheran Church
South Dakota Department of Health/Comprehensive Cancer Control Program
South Dakota Department of Health EMS
Great Plains Quality Innovation Network
Sanford Magnet Program
Active Generations
Frontier and Rural Medicine Program (FARM)/Sanford Medicine
Center for Ethics and Caring
Avera Center for Public Policy
Avera Hospital
Rapid City Regional Health
Gerontology Field Specialist
South Dakota Life Circle: Partners Improving End-of-Life Care

OCCUPATIONS REPRESENTED: Nursing, social Work, medicine, clergy, hospice and palliative care specialists, and other health sciences disciplines that integrate ACP and interprofessional education into their practice
OVERVIEW: In order to meet South Dakota’s need for a unified approach towards Advance Care Planning (ACP), the University of South Dakota’s (USD) Department of Nursing assembled an interprofessional, collaborative network of health professionals to pilot an ACP process. The ultimate goal is to implement a process statewide. The project starts by training learners in USD’s School of Health Science as “First Steps Facilitators,” based on the model pioneered by the Gunderson Respecting Choices® program. Following initial implementation of the training in Sioux Falls, ACP Facilitator training will be integrated into USD’s Health Sciences’ curriculum at USD campuses throughout the state. Trained facilitators will implement the approach to ACP at a number of intervention sites in Vermillion, South Dakota. The community was chosen because it has a hospital, a senior center, and a nursing home that already partner with USD as part of the health sciences curriculum. If the intervention has positive results, it will be scaled up to a state-wide level. A pre-post design will be used to assess the impact of the unified approach to ACP on the state.

PROJECT STUDY QUESTION:
How does the ACP initiative impact:
• Students’ attitudes and skills around interprofessional practice?
• Providers’ communication and collaboration in interprofessional teams?
• Client satisfaction, knowledge, and completion rate of Advanced Directives?
• Population-level health care outcomes in South Dakota?
INTERPROFESSIONAL TEACH BACK APPROACH TO PATIENT CARE

STATE: South Dakota
MEMBER SINCE: June 2015

PARTNERS:
Augustana University
Dakota State University
Dakota Wesleyan University
Sanford Health: Sioux Falls Region, Pulmonary in-patient unit
South Dakota State University
University of South Dakota

OCCUPATIONS REPRESENTED: Nursing, Pharmacy, Respiratory Therapy

OVERVIEW: The purpose of this project is to determine if an interprofessional team of clinicians and students, working together using a standard teach back method, may improve the quality of the patient’s discharge transition, have a positive effect on Sanford team and student collaboration, improve the patient experience of care, and decrease cost while preventing 30-day readmissions.
PROJECT STUDY QUESTION:
• Does an interprofessional (IP) team including IP students, working together using a standard teach back method, improve the quality of patient discharge transitions from the Pulmonary unit?
• Does an interprofessional (IP) team, including IP students, working together using a standard teach back method, have a positive effect on dimensions of team collaboration?
• Does an interprofessional (IP) team including IP students, working together using a standard teach back method, improve the patient experience of care?
• Does an interprofessional (IP) team including IP students, working together using a standard teach back method, reduce the cost by decreasing 30-day readmissions.

Phase 1: An interactive teaching intervention highlighting components of teach back, motivational interviewing, and patient self-efficacy was delivered by an interprofessional team to an audience of nurses, pharmacists, and respiratory therapists. Prior to the intervention, an instrument called the Collaborative Practice Assessment Tool (CPAT) was administered to explore dynamics of the interprofessional team and assess the perception of teamwork within the work environment. The goal of Phase I for the clinicians is to work together in an effort to deliver a standardized approach to patient education. Weekly reminders are provided along with periodic tracers to assess integration of the intervention. A post assessment of the CPAT was delivered at the end of phase 1 (end of May 2016). The data from the survey will be grouped together and sent to the National Center for additional data analysis. Along with the CPAT survey, patient readmissions are being tracked along with results from the Press Ganey Hospital Consumer Assessment of Health Plans (HCAHPS) unit-level patient experience indicators. Tracer surveys have been administered by the interprofessional leadership team throughout Phase I to determine progress and serve as a reinforcement of shifting culture expectations. Results of these tracers and aggregate data that demonstrates behavior change will be reported to the NEXUS.

Phase 2: This interactive teaching intervention will be delivered to all pharmacy, nursing, and respiratory therapy students who participate in clinical rotations on the pulmonary unit during the fall of 2016 and spring of 2017. A pre/post assessment of the CPAT will be used to measure both student and employee perception of interprofessional team and teamwork dynamics within the pulmonary unit. It is anticipated that similar follow up activities will be carried out as noted in Phase I. Additionally; case managers will be measuring self-rated patient confidence levels prior to discharge and 72 hours thereafter regarding their plan of care. We are coordinating this work with our academic partners as we scope out learning opportunities together. The intervention will entail scripting for students, targeted evaluation components for students, and development of interprofessional student collaborative activities within the clinical environment.
TRANSDISCIPLINARY OBESITY PREVENTION (TOP)

STATE: South Dakota
MEMBER SINCE: June 2015

PARTNERS:
South Dakota State University (SDSU)
South Dakota State University Extension, Food & Families Program
University of South Dakota (USD)

OCCUPATIONS REPRESENTED: Nutrition, dietetics, exercise science, early childhood education, journalism, nursing, public health, biostatistics, and counseling.

OVERVIEW: SDSU created a nine credit graduate certificate in Transdisciplinary Obesity Prevention (TOP). Students from all disciplines with an interest in childhood obesity prevention can earn the certificate as part of their elective credits while working towards a graduate degree in their respective disciplines. The learning environments for TOP include collaborative, transdisciplinary team learning via coursework and experiential learning experiences in childhood obesity prevention through community outreach with SDSU Extension. Graduates take seven core credits that were created specifically for the TOP program (Transdisciplinary Obesity Prevention I, 3 credits; Transdisciplinary Obesity Prevention II, 3 credits; and Practicum: Experiential Learning Experiences in Transdisciplinary Obesity Prevention, 1 credit) and two elective credits with approved student learning objectives consistent with the goals and objectives of the TOP certificate. Using a transdisciplinary team of experts in childhood obesity, students are introduced to the interrelationship of topics presented in the Social Ecological Model (SEM) for Nutrition and Physical Activity Decisions. Students are also introduced to the Evidence Based Public Health Framework, The Social Determinants of Health, Community Based Participatory Research, Grant Writing, and Dissemination of Research to the Scientific and General Public Communities. An emphasis will be placed on student interdisciplinary teamwork to address the transdisciplinary issues surrounding childhood obesity prevention. The practicum course enables students to apply course concepts in community settings and gain experience working collaboratively with a multitude of disciplines on childhood obesity prevention initiatives. This project focuses on changes among graduate students regarding attitudes and skills that impact their capabilities for addressing population health. Surveys and other assessment tools are used to assess changes over time.

PROJECT STUDY QUESTION:
• In a population of graduate students enrolled in the TOP graduate certificate program, what is the effect of collaborative learning on changes in personal and professional perceptions and attitudes in communication, teamwork, interprofessional education and interactions over the course of two academic semesters?
FOUNDATIONAL INTERPROFESSIONAL EDUCATION AS PREPARATION FOR COLLABORATIVE PRACTICE

STATE: Tennessee

MEMBER SINCE: December 2015

PARTNERS:
East Tennessee State University (ETSU) Quillen College of Medicine
ETSU College of Public Health
ETSU College of Nursing
ETSU College of Pharmacy
ETSU College of Clinical and Rehabilitative Sciences
ETSU College of Arts and Sciences, Departments of Psychology and Social Work

OCCUPATIONS REPRESENTED: Students from audiology, dental hygiene, medicine, nursing, nutrition, pharmacy, physical therapy, psychology, public health, social work, and speech/language.

OVERVIEW: This project is a classroom-based study of a foundational-level IPE curricula which aims to prepare students for advanced training in collaborative clinical practice models. The curriculum teaches team-care skills that have been shown to improve the Triple Aim. It utilizes the Preceptors in the Nexus Toolkit as well as TeamSTEPPS resources. Students participate over four semesters.
This project is structured around two primary objectives: 1) engage students in training that builds knowledge and values around current healthcare policy; and 2) increase students’ knowledge and skills around evidence-based team-care practice. It builds on prior work by evaluating observable knowledge and skills known to improve care. Student outcome measures will include changes in attitudes, knowledge and skills in areas of team work, communication, and collaboration.

PROJECT STUDY QUESTION:
• Among students participating in a entry-level IPE curricula, how does targeted training in health care and specific skills in the four core competencies (teams, roles, values, communication) affect knowledge and skills development?
INTERPROFESSIONAL COLLABORATIVE PRACTICE SERVICES FOR CARDIOVASCULAR RISK REDUCTION

STATE: Texas

MEMBER SINCE: March 2016

PARTNERS:
Texas Tech University Health Sciences Center, Schools of Nursing and Pharmacy
Larry Combest Community Health and Wellness Center

OCCUPATIONS REPRESENTED: Students and professionals including behavioral health specialists, clinical support staff, community health workers, dietitians, nurses, nurse practitioners, pharmacists, psychologists, and social workers.

OVERVIEW: The specific objectives of this Nurse Education, Practice, Quality and Retention (NEPQR) Project are to reduce cardiovascular risk through Chronic Disease Management (CDM) provided by interprofessional collaborative practice (IPCP) team; provide services to enhance the quality of care to the most vulnerable and high risk populations through IPCP; provide opportunities for interprofessional teaching and learning experiences for health professions students; and improve access to quality care for vulnerable individuals in Lubbock and surrounding counties.

Located at the Larry Combest Community Health and Wellness Center, this project aims to provide timely, effective, efficient and equitable health care services to its target population. The focus is facilitation of chronic disease self-management among the participants through team based care and supported by enabling services that concentrate on social determinants of health. This project uses the Transformation for Health Conceptual Framework and Bale/Doneen Methods in its implementation and evaluation.

Patient outcomes measured for this project include HgA1C, blood pressure, body mass index, inflammatory bio-markers, emergency room visits, hospital stays and length of stay, and medication adherence. Additional behavioral variables include self-efficacy, presence and use of social support, and health literacy.

PROJECT STUDY QUESTION:
• What are the outcomes of the TeamSTEPPS training conducted among the IPCP team?
• What are the clinical and behavioral outcomes of the Cardiovascular Risk Reduction Intervention in Chronic Disease Management among vulnerable populations evaluated by pre- and post-intervention measures?