EDUCATIONAL MODELS FOR INTERPROFESSIONAL PRACTICE
THINK TANK

COLLEGE OF PHARMACY
The University of Tennessee Health Science Center
Memphis • Knoxville
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In August, 2008, Dean Gourley announced the appointment of a College of Pharmacy “think tank” group to study the issue of interprofessional practice models and how the College of Pharmacy might incorporate such models more effectively in the curriculum.

Members of this group included the following:

**MAX D. RAY, PHARMD, MS, LHD** (Chair)  
Professor, Pharmaceutical Sciences  
College of Pharmacy

**STEPHANIE J. PHELPS, PHARMD**  
Professor, Clinical Pharmacy and Pediatrics  
College of Pharmacy

**BENJAMIN N. GROSS, PHARMD**  
Assistant Professor, Clinical Pharmacy  
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Dean and Professor  
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**TIMOTHY H. SELF, PHARMD**  
Professor, Clinical Pharmacy  
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Assistant Professor, Clinical Pharmacy  
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**DAVID K. SOLOMON, PHARMD**  
Associate Dean and Professor  
College of Pharmacy

**M. SHAWN MCFARLAND, PHARMD**  
Assistant Professor, Clinical Pharmacy  
College of Pharmacy

**KATIE J. SUDA, PHARMD**  
Associate Professor, Clinical Pharmacy  
College of Pharmacy

**CHARGE TO THE THINK TANK GROUP**

To develop specific, implementable recommendations regarding the establishment of “real world” interprofessional practice models that could be used in the education and training of pharmacy students (and other health professions students) at the University of Tennessee Health Science Center.
BACKGROUND

There has been considerable discussion in recent years about the need for and desirability of interprofessional practice models in health care delivery. Yet, it seems difficult for individual professions (or individual practitioners) to break out of the entrenched “silo” models that we have all grown up with.

The Institute of Medicine, in its 2003 report titled *Health Professions Education: A Bridge to Quality*, made a strong case that all health care professionals should be prepared to work in interdisciplinary (interprofessional) teams. The accrediting bodies of the various health professions schools and colleges (the Accreditation Council for Pharmacy Education and its counterpart organizations) are all setting expectations that health professions education will include meaningful experience during the student’s formative years in interprofessional health care delivery.

PROCESS

Prior to the Think Tank group’s first meeting a set of key articles (selected from a variety of sources, but primarily from the health professions education literature) was identified and provided to each member. Each member was given an opportunity to help in the selection of these background papers. These papers provided a frame of reference for discussions at each of our meetings. A complete list of the references used by the Group is attached (Appendix 1).

The Think Tank group met three times between November, 2008 and March, 2009. Each meeting was in the range of 3 to 4 hours in duration. All meetings were held in Memphis; members in Kingsport and Nashville were connected to the meetings by speaker phone. E-mail communications allowed the group to accomplish a number of specific tasks between scheduled meetings.

At its first meeting (held on November 7, 2008) the group reviewed its charge and agreed on the following process to guide its work:

*Adoption of an “STP” approach to problem identification and resolution*

We will first try to agree on what the problem is that we want to address. This can be called the current Situation. (In other words, what’s broke?) It is important that we have a common understanding of the problem we will be working on.

Next, we will pool our thoughts on what the Target is that we’re trying to achieve. What does a successful outcome “look like”? This should be as specific and graphic as we can make it. We should all agree on this vision of the endpoint.
Third, (and this is the toughest part), we will develop a Proposal for how we move from where we are (S) to where we want to be (T). The proposal should include specific, achievable, measurable intermediate steps. (This is really a strategic plan.)

\[
\begin{align*}
S &= \text{current Situation (i.e., a description of “what’s wrong”) } \\
T &= \text{Target (i.e., desired outcomes) } \\
P &= \text{Proposal to achieve the desired outcomes (i.e., a roadmap to get from } S \text{ to } T) \\
\end{align*}
\]

**Pooling our latent information and knowledge**

Members of the group will each be encouraged to share their experiences with the topic of interprofessional practice models, offer opinions based on their experiences, and/or summarize what they have learned from reading the literature or discussing the topic with colleagues who have had some experience in this arena. In this step, we are learning from each other.

**Literature review**

Key articles from the literature will be reviewed and discussed. (Appendix I)

**Identification of questions that need to be answered**

Based on steps 2 and 3, the group will identify gaps in our knowledge that need to be addressed. These needs might be addressed by 1) data collection and analysis, 2) bringing in an expert consultant, or 3) a combination of 1) and 2).

**Regrouping after we have answered the questions**

As a group, we will consider what we have learned through the exercise described in step 4 above. We may at this point uncover additional questions that need to be addressed. This is an iterative process.

**Developing a set of tentative recommendations**

The “deep thinking” part of the process occurs here. We will need to think creatively, boldly, and synergistically. We will need to take lessons from past failures, but not be too quick to conclude that what didn’t work in the past can’t work in the future. The output from this step is a tentative roadmap from \(S\) to \(T\).
**Gestation period**

It is important to build in some time for reflection on the output from Step 6. This might be a week or two.

**Development of final report**

The final meeting of the group will be devoted to refining its recommendations after having had time to reflect on the group discussion in step 6. The final recommendations should be supported by a narrative that helps the reader understand how the recommendations were arrived at.

Although the College of Pharmacy is sponsoring this Think Tank group, it is hoped (expected) that the recommendations will apply broadly to all health professions education programs and practice settings.

**PROCESS**

At its first meeting the group also identified three key questions that needed to be resolved:

1. Should the group’s efforts be directed toward interprofessional *education and training* models or toward real-world *practice* models (or perhaps both)?
2. What definitions will we use for the terms *interdisciplinary* and *interprofessional*? Which term better fits our purpose?
3. Who is the target audience for the group’s final report—the College of Pharmacy, or all programs on campus?

At its second meeting (December 17, 2008) the group discussed the background papers that had been previously circulated. Each member was assigned two papers in advance and was requested to serve as the discussion leader for those papers. Following review of these papers the group had a rich discussion on “what we learned.” At the end of this discussion the group concluded that, given the complexity of the topic of interprofessional health professions education, it would be appropriate to bring in a consultant (someone with a track record of success in this area) to work with us.

In addition, the group settled on the following responses to the questions framed during its first meeting:

1. The focus of the think tank group should be on education and training models, rather than on practice models. This position was taken with full realization that good practice models are essential for teaching; however, the group felt that recommendations regarding the establishment of practice models lay outside its purview.
2. The group agreed that the term “interprofessional” served its needs better than “interdisciplinary.” (See definitions under Findings below.)
3. The group agreed that its primary “customer” is the College of Pharmacy, since the College appointed the group and gave it its charge. However, the group believed that its final recommendations should be useful to the entire campus.

After the second meeting the Chair developed a set of discussion questions (based on the outcomes of the first two meetings) and circulated for comment by e-mail. A copy of those questions is attached to this report (Appendix II). These questions were sent by e-mail with a request to provide written commentary (to be shared with the entire group). A summary of responses is included under Findings below.

Also subsequent to the second meeting, the Chair investigated potential consultants who might be invited to join the group at a future meeting. Based on conversations with leaders at the American Association of Colleges of Pharmacy and the Accreditation Council on Pharmacy Education, he learned that the University of Minnesota had a strong reputation in the area of interprofessional education. The Chair contacted the Dean of the College of Pharmacy at the University of Minnesota to get her thoughts on who might be appropriate to invite as a consultant. The Dean recommended that, instead of inviting one consultant to come to Memphis, it might be better to have someone from the Minneapolis visit to Minneapolis, to meet the entire group of individuals involved in their interprofessional health professions education program. Based on that advice, the Chair arranged to visit the University of Minnesota Center for Interprofessional Education. He visited there on March 13, 2009. A report on that visit is attached as Appendix III.

At its third meeting (March 19, 2009) the group discussed the following:

1. the report on the Chair’s visit to the University of Minnesota;
2. a summary of the responses received on the discussion questions that had been circulated by e-mail (Appendix III); and
3. results of a previous attempt at UTHSC to initiate a required course in interprofessional health practice (Course Number IP 844—Interprofessional Health Practice, which was offered in the 2005-2006 academic year—see Appendix IV).

At the conclusion of the March 19 meeting, the group concluded that it had sufficient information to respond to the charge given to it by the Dean. The Chair agreed to prepare a draft report for review/comment by individual members of the Working Group. The group would then decide if another meeting is needed.
DEFINITIONS

For the purposes of this think tank activity we found it necessary to agree on definitions of the terms *interprofessional* and *interdisciplinary*. Related terms that we also useful were *multidisciplinary* (or *multiprofessional*) and *transdisciplinary* (or *transprofessional*).

The group recognizes that the terms *interprofessional* and *interdisciplinary* are frequently used interchangeably and that the same is true for *multiprofessional* and *multidisciplinary*, and for *transprofessional* and *transdisciplinary*.

We first drew a distinction between a *profession* and a *discipline*. In doing so, we generated the following definitions:

A **profession** is a broad field of endeavor that is pursued by a wide range of practitioners, both at a generalist and a specialist level. Undergirding that profession is a general body of knowledge, skills and values that is shared by all the members of that profession.

A **discipline** is either 1) a specialized area of knowledge or 2) a narrowly-focused area of practice within a given profession.

The adjective *interprofessional* refers to a team or to a practice involving members of two or more professions, whose work is coordinated and integrated.

“*Interprofessional education occurs when two or more professions learn with, from and about each other to improve collaboration and the quality of care.*”

Center for the Advancement of Interprofessional Education

*Interdisciplinary* is used to describe a group or team composed of two or more disciplines. The disciplines represented may be from two different fields of knowledge (e.g., biology and physics), two different sub-disciplines within the same field of knowledge (e.g., neuropharmacology and psychopharmacology), or two specialties or sub-specialties within a given profession (such as pediatric endocrinology and neonatology).

*Multiprofessional* refers to a group composed of two or more professions whose members function in an independent, uncoordinated manner.

*Multidisciplinary* refers to a group composed of two or more disciplines that make independent contributions to the goals of the group, with no coordination or attempt at integration.
**Transprofessional** refers to a group made up of members of two or more professions who have certain knowledge and skills in common. The traditional professional boundaries become less rigid, allowing members of the team to work on problems not typically encountered by or seen as the responsibility of their particular profession.

**Transdisciplinary** refers to a group composed of members of two or more disciplines, who have overlapping knowledge. Disciplinary boundaries are transcended; no member of the team is constrained by the limits usually associated with his or her discipline or sub-discipline.

In this report, the term **interprofessional** will be used to describe the type of educational model that we propose for adoption at UTHSC.

### CURRENT SITUATION

The group found that there are currently no required interprofessional courses on the UTHSC campus. Interprofessional experiences do occur during the experiential component of students’ education and training (i.e., during clinical rotations), but these experiences are random and unplanned. The quality and depth of such experiences will predictably vary from program to program, from student to student, and from setting to setting.

The group learned about a previous attempt (in the 2005-2006 academic year) to establish a required, campus-wide interprofessional studies course. This course was discontinued after one year. The group is not aware of any current attempt on campus to re-establish such a program.

There is increasing emphasis in the accreditation standards for the various health professions program to include interprofessional experiences in their respective programs. The current environment at UTHSC makes this goal difficult to achieve.

### TARGET (IDEAL SITUATION)

The group believes that an ideal environment for interprofessional education and training at UTHSC would include both classroom and clinical (practical) experiences. Support for the creation of such an environment would be both “top-down” and “bottom-up”; i.e., from the Chancellor’s office and from each Dean, as well as from individual faculty members and clinical preceptors.

In the ideal environment there would be both required and elective interprofessional courses. The required courses would extend to students in all programs on campus (with the possible exception of students in the College of Graduate Health Sciences).
Students would graduate from UTHSC with a full appreciation and understanding of the roles of members of each of the health professions. They would have learned how to function in interprofessional teams, and to provide appropriate leadership on the team.

There would be an “interprofessional culture” on the UTHSC campus.

**PROPOSAL (RECOMMENDATIONS)**

The think tank group offers the following observations and recommendations, relative to the establishment of interprofessional education and training opportunities for pharmacy students (as well as all other students) at UTHSC:

1. The group believes there is little that the College of Pharmacy can do, on its own, to promote interprofessional education and training on the UTHSC campus. The College could, on the other hand, seek to engage other programs on campus in discussion on this topic, with a view toward issuing a joint statement in support of interprofessional education as a major goal for the UTHSC campus.

2. There should be a declaration of commitment to the goal of interprofessional education at UTHSC, coming from the Chancellor’s office. Deans and department chairs should be involved in building support for such a goal.

3. Champions for interprofessional education and training should be identified from among both full-time and adjunct faculty members. These individuals should be given a major responsibility for planning and designing interprofessional learning experiences.

4. A central office for interprofessional education should be established on the UTHSC campus. The director of this office should be given appropriate authority and financial support to operate a meaningful program. (The group believes the Center for Interprofessional Education at the University of Minnesota provides a good model for such an office.) This office would have responsibility for the following:

   - faculty development in the area of interprofessional education and training
   - development of outcome objectives for interprofessional education and training
   - establishment of a curriculum for interprofessional education and training (including didactic instruction, student-centered learning, and clinical experiences)
   - review and approval of course proposals (required and elective)
   - assessment of student learning
   - encouraging the development of more interprofessional practice models throughout the community
   - build appropriate alliances between UTHSC and the practice community, to advance interprofessional education and training.
APPENDIX I
LIST OF REFERENCES


Kirch DG. A word from the President: “Interprofessional collaboration: we are willing—can we find the way? AAMC Reporter: May 2008. Available at www.aamc.org/newsroom/reporter/may08/word.htm; accessed November 1, 2008.


APPENDIX II
SUMMARY OF RESPONSES TO PROPOSED DISCUSSION QUESTIONS FOR THE “THINK TANK” GROUP ON EDUCATIONAL MODELS FOR INTERPROFESSIONAL PRACTICE
March 19, 2009

CONFIRMATION OF THE VALUE OF INTERPROFESSIONAL DELIVERY OF HEALTH CARE

Has the working group settled on a definition for “interprofessional”? Have we satisfactorily distinguished between the meanings of “interprofessional” and “multiprofessional” and between “interprofessional” and “interdisciplinary”? Do we agree that the term “interprofessional” is preferable to “interdisciplinary” for our purposes?

The consensus is that we do have a good understanding of these terms, and that we should adopt the term “interprofessional” for our purposes (rather than “interdisciplinary”)

What are the goals of interprofessional health care delivery? (The answer to this question can be based on what others have written as well as on our own thinking on the subject).

- Improve the quality of health care cost-effectively.
- Improve education to health care trainees.
- Enhanced sharing of knowledge and skills.
- More effective communications.
- Error reduction.
- Ensure optimal patient care and outcomes, including application of evidence-based medicine in the most compassionate way possible.

Goal is to take a group of individual health care professionals and combine them in a way to improve the delivery of care to the patient. It is focused on moving the practitioner away from a “silo” health care model. IP models allow practitioners to consider the bigger picture and focus on similarities among professions versus differences.

What do we know about the value of interprofessional health care delivery (as compared to the uncoordinated or loosely coordinated care provided by the members of a variety of professions)? What did we take away from our review of the literature and the discussions at our first two “think tank” meetings (November 7 and December 17) on this question? What have we learned? Are we satisfied that we have distinguished between what we think and what we know?

- Rigorous studies are lacking to answer this question.
- Not sure, but there has been so much talk about IP practice and education that surely some data are beginning to be gathered. The College of Nursing has a research team
that is looking at simulation to enhance IP communication in critical incidents (much like pilots use flight simulation).

- Lack of well designed and well conducted studies to validate. Designing a study using an IP model would be paramount, but eliminating biases would be difficult.

Does our knowledge about the value of interprofessional health care delivery lead us to conclude that this is an essential goal for all health professions (including pharmacy)?

- Accrediting bodies have already decided that this must be an essential goal. A few high quality studies back this up, but a large amount of evidence is not available.
- I believe we have moved toward this model in most settings; unfortunately, in the private, non-hospital setting there are many limitations to pharmacists being able to implement this concept. Major problem for pharmacy is lack of provider status and inability to receive adequate payment for IP services.

THE FOLLOWING TWO SETS OF QUESTIONS ARE BASED ON THE ASSUMPTION THAT THE GROUP’S RESPONSE TO THE ABOVE QUESTION IS AFFIRMATIVE. WHAT ARE THE ESSENTIAL ELEMENTS OF A SUCCESSFUL INTERPROFESSIONAL PRACTICE MODEL FOR HEALTH CARE DELIVERY?

Which professions are required at a minimum for a successful interprofessional practice model? Who should make this decision? Are the same professions required in every situation?

- MD and RN will likely be required in all clinical situations. Others (including pharmacists) should be included depending on the situation.
- Where drug therapy is involved, a pharmacist should be a member of the team.

Do we take it as a given that interprofessional health care delivery is (or should be) team-based? If so, who should lead the team? Should it always the same individual? How should this question be decided, and by whom?

IP care delivery should be team based, although the members of the team may vary according to the situation. The team leader will often be an MD, but it could be someone else (RN or PharmD, for example), depending on the problem the team is dealing with.
What system of communication must be established to allow each member of the interprofessional team to make his/her best contributions? What particular obligations does the physician-member of the team have in ensuring good communications? (Since it is in most cases a physician who is making a diagnosis and setting the general goals for treatment, how should the physician communicate his/her goals for treatment to the rest of the team? What information does each of the other members of the team need in order to make his/her contributions to successful patient care outcomes?)

- There should be a “no fault” atmosphere, with the attitude that everyone is there to learn and to contribute. The team leader (physician or other) should seek input from each member of the team.

- Each member of the team needs to have access to all relevant clinical information, and each should have the authority to write orders or progress notes according to the responsibilities they have on the team.

- I don’t agree that physicians always set goals. They seem to focus on acute issues very well but do not set goals regarding chronic disease states very effectively. Each member of the team should participate in goal-setting.

- The answer to these questions is situational, cultural, and based on trust.

Since health professions education has not traditionally included any type of structured exercises in their various curricula on interprofessional collaboration, most health professionals have entered practice without any formal education or training in teamwork. What are the characteristics (essential elements) of a high-performance team? How could the effectiveness of currently-functioning teams be assessed? Where the need for improvements in teamwork is identified, how could such needs be addressed?

- Research is probably needed to look into these questions.
- I don’t agree with the premise of this question. There are good IP models for pharmacy students in their clinical rotations; however, not all rotations provide good models.
- Essential elements are listening, evaluating opinions, and incorporation of ideas into an action plan.
- Effectiveness should be evaluated based on achievement of set performance measures. Quality of care surveys for patients and work environment satisfaction surveys for providers.
- Improvements won’t likely occur unless they are supported from the top of the organization. They also won’t occur unless supported by practitioners and educators. Strong leadership is required, which includes building support for the vision among those who can achieve it.
How should we think about the relationship between an interprofessional team and the patient? What points can we agree on?

- It’s about patient care, not the needs or egos of individual team members.
- We should think of the patient perhaps as a “partner,” rather than a team “member.” The patient is the focus of the team’s efforts; the team should seek to engage the patient in all decisions regarding care delivery.

ELEMENTS OF AN EDUCATIONAL MODEL FOR INTERPROFESSIONAL HEALTH CARE DELIVERY

What should we (those of us in health professions education) be teaching all our students about teams and teamwork? About the value of/necessity for interprofessional collaboration?

- Team-building exercises with colleagues and students in other professions.
- Students should learn that IP health care delivery is better for patient care, and more cost-effective.
- Where it is possible to integrate students from different professions in the classroom, this should be done. However, each profession should be taught to focus on what it does and to do it with excellence.
- All students should be taught excellent, evidence-based, cost-effective care.
- Required vs. elective experiences—both can work, and both can fail.
- Co-curricular (extra-curricular) activities are very valuable in interprofessional learning.
- We can put students in an interprofessional environment, but that does not guarantee that they will learn. Active learning is essential.

On our campus, who should be responsible for spearheading an effort to incorporate educationally-sound interprofessional experiences in the curriculum of each program? Do we have the collective will to make this happen?

We probably don’t have the will at this time, given the impact of budget cuts.

- Perhaps CTSI should spearhead this effort.
- Each dean must make this a high priority. If it doesn’t happen top down, it won’t succeed.
- Faculty workload must be taken into account in the design and implementation of any new courses or programs (including those directed toward interprofessional education). IP education will not work unless faculty members have the time to devote to it.
Do we have adequate models in place for teaching interprofessional practice skills? If not, what steps should be taken to establish such models?

- No. Maybe we should issue an RFP to study current models.
- Yes, I believe the structure is in place. In pharmacy, the 3rd and 4th year rotations offer the best opportunity for developing this type of collaboration.
- We should seek to build on models that already exist.
- Successful models should be given as much visibility as possible. They should be described in the literature.

What range of options can we suggest for interprofessional educational experiences (e.g., collaboration on case studies, clinical rotations)? What are the advantages/disadvantages of each? Which ones would we recommend for adoption campus-wide?

- Experiences on clinical rotations are the best. This may come too late in the curriculum to be effective, but it may be the best we can do in the “real world” scenario.
- Implement didactic courses that emphasize team building opportunities. MD training needs to emphasize that they can’t and should not be expected to do everything alone.
- Interprofessional participation in CLARION competitions, journal clubs, and responding to drug information requests.
- Use of high-fidelity simulators and standardized patients in interprofessional training exercises.

How could/should interprofessional educational activities be assessed?

- Using a validated tool.
- A well-designed study evaluating not only specific outcomes, but patient and provider satisfaction would be ideal. However, I don’t think that measuring a change in environment will be ultimately quantified. It will be a change in overall healthcare delivery that will be achieved.
APPENDIX III
REPORT ON VISIT TO THE UNIVERSITY OF MINNESOTA CENTER FOR INTERPROFESSIONAL EDUCATION
Max D. Ray, PharmD
March 16, 2009

At its December 17, 2008 meeting, the “think tank” group concluded that it would be beneficial to invite a consultant to meet with us at our next meeting. Subsequent to that meeting the Chair investigated possible consultants, looking for individuals who had had experience with interprofessional health education programs and who might be willing to share their experience with our group. This led to our contacting Dr. Marilyn Speedie, Dean of the College of Pharmacy at the University of Minnesota in Minneapolis, who has been a champion of interprofessional education for a number of years.

Based on a telephone conversation with Dr. Speedie, it was concluded that a good first step for us might be to visit their campus, to meet with several of the key people there who have been involved in developing interprofessional education programs for the various health professions students. Based on that invitation, the Chair traveled to the University of Minnesota to meet with Dr. Speedie and several of her colleagues. This meeting occurred on March 13.

Individuals included on the itinerary were:

- Marilyn Speedie, PhD, Dean of the UM College of Pharmacy
- Barbara Brandt, PhD, UM Vice President for Continuing Professional Development
- Tom Larson, PharmD, Associate Dean for Clinical Affairs, College of Pharmacy
- Tom Lackner, PharmD, Associate Professor of Pharmacy Practice and a pharmacy practitioner in the interprofessional transitional care unit at Walker Methodist Hospital in Minneapolis
- Don Uden, PharmD, Professor of Pharmacy Practice and pharmacy coordinator for an interprofessional course
- Debbie Sisson, PharmD, Experiential Education Director for the College of Pharmacy’s Duluth campus
- Gwen Halaas, MD, Director of the UM Center for Interprofessional Education (CIPE)
KEY FINDINGS

1. Historically, the UM College of Pharmacy has encountered a number of challenges that we have faced at UT, including the following:

- lack of viable interprofessional practice models
- scheduling difficulties (students in the various professional programs have their own unique academic schedules, with no common times when they are all out of class)
- lack of faculty “buy-in” to the value of interprofessional education
- difficulties in creating suitable ratios for interprofessional teams or learning groups, because of the difference in class size from one professional program to another
- lack of resources

Some of these challenges remain, but some have been overcome.

2. Among the successful interprofessional education programs at UM (which involve pharmacy students) are the following:

- an interprofessional transitional care clinic run by Walker Methodist Hospital, which provides opportunities for pharmacy, medicine and nursing
- a rural-health orientation program for first-year pharmacy and medical students
- various didactic courses which include instruction on the specific roles and value of the various health professions

3. A turning point for interprofessional education at UM was the establishment (in 2006) of a central office called the Center for Interprofessional Education (CIPE). The following statement from the Center’s Charter defines its purpose:

The Center for Interprofessional Education will work collaboratively with AHC schools, colleges, centers, faculty, students and staff to identify, promote, implement and evaluate interprofessional education in a continuum of activities across the educational lifespan. The Center will facilitate the creation of a vertically integrated interprofessional curriculum that leads to expected student outcomes. The Center will provide support for approval pathways and oversight for the development, management and evaluation of interprofessional education opportunities (curricular and co-curricular; content-based and experiential) in the AHC. The Center will provide and support faculty development specific to interprofessional education. One of the Center’s key functions will be to support short-term faculty work groups that will be formed to develop discrete interprofessional courses and experiences.
The CIPE has adopted the following definition (which was first established by the United Kingdom Center for the Advancement of Interprofessional Education):

*Interprofessional education is the process by which two or more health professions learn with and about each other across the spectrum of their education to improve collaboration, practice and the quality of patient-centered care.*

Expected outcomes established by CIPE are as follows:

*Students will know about the roles of other health professionals; students will be able to work with other health professionals in the context of a team where each member has a clearly defined role; students will learn how to apply disciplinary strengths of health professionals for their highest and best value in health promotion, prevention, and care delivery.*

A description of the Center for Interprofessional Education is available on its website: [www.ipe.umn.edu](http://www.ipe.umn.edu).
APPENDIX IV
UNIVERSITY OF TENNESSEE HEALTH SCIENCE CENTER
2005-2006 SYLLABUS

Course Number: IP 844
Course Title: Interprofessional Health Practice
Credit Hours: 3 semester hours
Placement: Ongoing throughout the student’s program of study

Students will be enrolled continuously, beginning with matriculation, with final course credit awarded the semester of graduation.

Faculty:

Course Coordinator: The Course Coordinator will be responsible for assuring all students have access to course materials, chairing the Course Oversight Committee, coordinating the Course Symposium, and assigning the course grades. Academic Deans for respective colleges will be the individuals to input grade of Pass or Fall for student in last semester of enrollment at UTHSC.

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COURSE DESCRIPTION AND GOALS

Interprofessional Health Practice (IP 844) provides a framework for all health professional students to discover the benefits of a practice that actively engages all health professions. The course will focus on the role and scope of practice of various health professions, how teams function and the benefits of teamwork. The course emphasizes effective patterns of communication and collaboration among health care team members. This course is designed to initiate an interprofessional learning practicum for health professions students from Allied Health (physical therapy and occupational therapy), Social Work, Pharmacy, Nursing and Medicine. Students will learn to conceptualize health beliefs and behavior from a biopsychosocial framework, and they will learn to assess health care needs and limitations to health care access through an interprofessional experience. Students will learn to better appreciate the system of healthcare, the needs of the community and their role as both an individual specialist and their unique role within the interprofessional structure of the healthcare system.

COURSE OBJECTIVES

1. Demonstrate knowledge of and respect for overlapping roles and distinct competencies of different health professionals.
2. Communicate and collaborate professionally and therapeutically with students from different health care professions.
3. Apply knowledge gained in their respective disciplines to health situations and community projects and practice.
4. Additional objectives

COURSE OUTCOMES

At the conclusion of this course, students will be able to:

1. Demonstrate an effective interprofessional practice.
2. Engage other health professions in learning and patient care activities.
3. Communicate effectively with the interprofessional team.
4. Provide safe, timely, effective, efficient, equitable, and patient-centered care in an interprofessional practice.
5. Identify the relevance of interprofessional practice for addressing clinical and social problems that affect the health of individuals, communities, and populations.
COURSE PARTICIPANTS AND STRUCTURE

IP Health Practice is composed of online informational videos, small group discussions and community practice and projects, and interviews. IP Health Practice includes students and faculty from the Colleges of Allied Health, Social Work, Pharmacy, Nursing and Medicine. Students will work in interprofessional teams with at least three disciplines represented for patient interviews and other projects.

Large Group Orientation: Matriculating students will have an orientation on the fourth Thursday of August during Chancellor’s Hours. The introduction will expose the student to the importance of interprofessional education and to the course objectives. Interprofessional student team assignments will be handed out at this time.

Online Training (Phase I): Students will review a series of videos and complete an online pre-test and post-test at their own pace in the fall semester of matriculation. This phase will be completed prior to the first small group meeting and will provide an overview of the health professions to the student.

Small Group Discussions (Phase II): The discussion groups will consist of 12-15 students from the five colleges with 1-2 faculty leaders per group. Discussion groups will meet two times in the fall semester and two times in the spring semester of the first year. Discussions involve content to orient students to interprofessional points of view on healthcare, healthcare life-span topics, communication and interviewing skills, team building activities and simple physical assessment skills.

Interprofessional Opportunities (Phase III): This phase of the course will be met throughout student’s respective educational program of study. Opportunities identified as interprofessional on the service training website will qualify. Some opportunities will be community focused, and others will be clinical in nature. Credit for participating in these events will occur upon completion of Phase II of the course.
COURSE OUTLINE

1. Phase I: The health professions online training. Independent study via Blackboard,
   Viewing of video presentations
   a. Qualifications of various health professions
   b. Becoming a health care professional – student and practitioner perspective
   c. Patient-centered care of different professionals
   d. Case scenarios – you pick your team

2. Phase II: Team building
   Small group interaction’s and general team-building principles
   a. Work shop activities
   b. Benefits of interprofessional health practice

3. Phase III: Interprofessional communication and collaboration
   Participation in interprofessional group projects, practice and symposia
   a. Learning and working together through (Clinical Projects and/or practice/Experiences)
      and service learning activities.
   b. Sharing experiences via Symposium.

FIRST YEAR SCHEDULE

August 25, (Thursday)
1:00- 2:00 pm
Students Orientation (faculty invited): (Schreier Auditorium)
Chancellor Introduction, Importance of Interprofessional learning, Course objectives and overview presented, assignments of interprofessional team and small groups.

August 25 – Sept 28th
Complete online sections. View all videos and answer questions. Students will discuss the online training at first small group meeting.

September 29th
12:00 – 2:00 pm
First small group. Discuss online component of the course. Distribute list of professionals to interview as an interprofessional team.

Sept 29th - Nov 9th
Interdisciplinary teams interview health professionals at their own arranged time.

November 10th
12:00-2:00 pm
Second small group. Discuss interviews. Importance of Teamwork. Do team building exercise
EVALUATION METHODS

The course will be graded as pass/fail. A passing score is earned when:

1. Students satisfactorily complete the introductory Blackboard assignment (Phase I).
   
   A Pre-test and post-test will be completed.

2. Students satisfactorily complete a face-to-face team-building workshop, assigned projects and meet attendance requirements for group interaction (Phase II).

3. Students complete a series of projects/practice with students of other professions (Phase III).

XX number of activities (projects/projects) to be completed by the end of the first year, the remaining XX activities (projects/practice) can be completed at any time throughout the student’s program of study, but prior to the last semester in which the respective degree is awarded. All approved activities will be posted on website under course #IP 844. Credit will be awarded by the Faculty Sponsor or Community Sponsor for each activity (project/practice) and reported to the Course Coordinator. Requirements to be fulfilled in order for credit to be awarded will be detailed in each activity (project/practice) description.

ACTIVITIES OVERVIEW

Activities (projects/practice) will be designed by faculty members from colleges across the Health Science Center with the goal of providing opportunities for students to learn from each other, to develop interprofessional communication skills, to enhance their understanding of the contributions of various health professions, and to discover how collaborative efforts can enhance work outcomes.

Background Readings for Interprofessional Health Practice


Each of us has encountered situations in which we have tried to solve a complex problem with only part of the knowledge necessary to do so. Sometimes we are unaware of our deficits and continue in our solo attempts. Later, we realize that the solution will require knowledge that we
do not have and do not have time to acquire. In clinical health care settings, these dilemmas are common. In fact, we are bombarded by these situations. To address some of these dilemmas, wise health care providers elicit the help of others with appropriate knowledge, perhaps a professional from another discipline, an administrator, or a member of the support staff. However, when similar or complex problems arise frequently, those we ask for help might become irritated or resentful that we are asking so much of their time when they have their own jobs to do. This signals that the consultation process may be inefficient for these problems and that a more formal team effort with established expectations, goals, procedures, and responsibilities might produce better results.

Unfortunately, most clinical health care providers were trained in their own autonomous health professions and were not formally taught a foundation for team practice. Health providers begin working on teams because they realize that they cannot provide care alone for some patients. Clinicians’ intelligence and experience tells them that they need the help of professionals with different skills to provide care for patients who have complex problems. As clinicians begin to interact more closely with other care providers they realize that providers from different disciplines have philosophies that differ from theirs.

For example, faced with a brittle case of juvenile diabetes, a physician might frame the problem as a need to titrate medication and monitor glucose levels. A nurse might frame the problem as a need for family education and ongoing monitoring. A social worker might frame the problem as one of educating peers and caregiver stress. There are obvious overlaps in the three ways of framing this problem because “monitoring” might involve patient, caregiver, and perhaps peers. Because this case of juvenile diabetes presents as a wicked problem it might take all three disciplines working together to frame the problem so they can more efficiently resolve it.

How different disciplines are taught or not taught to work with practitioners from other disciplines is a major factor in whether they use the talents of other disciplines to help solve wicked problems. If practitioners from a certain discipline are taught to demonstrate an authoritarian leadership style it will be difficult for them to engage the willing services of other disciplines. If practitioners from another discipline are always expected to defer to other more highly trained practitioners it will hinder their willingness to offer constructive ideas for care. If practitioners from a given discipline are taught to “do their own thing” without taking into account the input of other practitioners, that is what they will do. All this affects the economics of team practice.

Effective teamwork requires good communication. Frustrated team members often express concerns about its quality and extent. As in any relationship between people, the ability to “keep the lines of communication open” in an interdisciplinary health care team (IHCT) is an important indicator of effective teamwork skills. In IHCTs, the dimensions of communication most often discussed relate to issues involving personality clashes, role overlap and conflict, and the effective use and sharing of clinically important information. Absent is an examination of underlying problems with communication based on the professional differences among health care providers, including how they acquired particular values over the course of their education and
subsequent clinical work experience. These values are related to their orientations both to the patient and toward each other.

For example, physicians tend to approach patients within a predominately biomedical model, emphasizing “objective” information from laboratory tests as a means to focus on increasingly narrow interpretations of the patient’s “problem.” Most nurses, however, tend to have a much broader view of the “patient as person,” which includes his or her interpretation of the meaning of the illness and its significance for everyday living. This more holistic approach to the patient’s problem embodies more qualitative dimensions, in contrast with the medical emphasis on quantitative, “factual” data as sufficient to understanding the problem. Unless these values and the assumption of their relative importance are made clear, physicians and nurse may have difficulty working together on an IHCT – because each has different views of professional priorities and the basic values that create these priorities.

Becoming a health care provider means acquiring the knowledge, skills, values, roles, and attitudes associated with the practice of a particular profession. The very fact that there are different health care professions suggests that each health care discipline tends to see itself as unique in the nature of basic practice framework into which its students are inducted, trained, and credentialed—as well as in the workplace and clinical practice settings in which they subsequently work. This process is in many respects similar to how different cultures socialize their members into the unique ways of thinking and acting that characterize them, based on shared views of the world, guidelines for individual action, and collective values that bind the community together.

Extending this metaphor to health professions education offers fresh insight into how new “inductees” in health professions training programs are usually protectively housed in different buildings on campus—called colleges or schools—where they can be free from the potentially contaminating and threatening influences of students and faculty from other fields. Similar courses may be taught independently for students in different health sciences programs, reinforcing the relative insularity and parochialism of educational processes at the university or college level. The acquisition of unique patterns of language, modes of dress and demeanor, and norms of behavior are all outward manifestations of this inward transformation. Indeed, some commentators have even argued that exposure of students to health disciplines different from their own would only serve to confuse them and threaten their emerging sense of identity. Only when the student is sufficiently socialized into this identity do we allow him or her to have clinical contact with other professions, usually following graduation.

The significance of this history-taking method has been studied, and it has been noted that the nature of the language and discourse—or “talk”—between doctor and patient is the main ingredient in medical care and the very foundation on which treatment and care goals are built. Language analysis applied to the medical interview reveals that there is a wide cultural gap between the life world of the patient and the scientific-technological domain of the physician. The two distinct voices of medicine and the patient represent different “provinces of meaning” or
“modes of consciousness” that limit the physician’s ability to understand and appreciate the patient’s real-world concerns and life goals.

**Turning no to yes: how to motivate the reluctant patient.**

Author: Deborah Grandinetti  
*Medical Economics, June 15, 1998*

Want to hone your skill at influencing patient behavior? Here's an approach that's not only tested, but time-efficient.

Maimonides, the 12th-century physician, philosopher, and rabbi, is said to have prayed daily: "Grant that my patients have confidence in me and my art, and follow my directions and my counsel."

Of course, Maimonides wasn't contractually at risk for his patients. Perhaps you are. That can make it doubly frustrating when a patient doesn't adhere to a treatment regimen.

The overall rate of patient compliance is a disappointing 50 percent. That rises to about 60 to 70 percent for patients with symptomatic conditions, but dips to 40 percent or less for those with chronic or asymptomatic illnesses such as hypertension, says internist Geoffrey H. Gordon, associate director of clinical education at the Bayer Institute for Health Care Communication in West Haven, Conn.

But don't throw in the towel just yet.

With the right strategies and some practice, you can become much more effective at helping even the most resistant patients. In Gordon's words, "It's well-documented that the way you interact with patients influences their behavior and outcomes." The trick, he says, is to use highly focused techniques that let the patient determine the pace of behavioral change while building his motivation over time and deflecting his resistance.

Once you become proficient at this, you'll probably find it enjoyable. So say physicians who have upped patient compliance by using a new and increasingly popular in-office approach. The method draws heavily on two decades of research in behavioral change, most notably the "stages of change" theory advanced by research psychologists James O. Prochaska and Carlo DiClemente, and the "motivational interviewing" technique of research psychologists William R. Miller and Stephen Rollnick.

These strategies have been adapted for physicians and require just a few minutes during an office visit - often less time than it takes to lecture a patient.

Why the traditional route seldom works
If you’re like most physicians, you rely on the time-honored "advise and educate" approach. Maybe you tell a diabetic patient, "You'd do yourself a big favor by dropping 50 pounds, and I want you to be much more consistent at monitoring your sugar levels."

You really want her to succeed, because you know what awaits her if she doesn't. So you explain the medical reasons why, and hope for the best.

Sometimes this works. More often, it doesn't. Here's why:

Telling patients what you want them to do rarely strengthens their internal motivation. Moreover, if you repeat unwanted advice, you may alienate patients and cause them to dig in their heels. One of the biggest weaknesses of the "advise and educate" approach is that it does nothing to help patients get past the natural human resistance to change. The other problem is that change isn't an event, it's a process. And people need different kinds of assistance, depending on where they are on the change "continuum." This has been borne out in studies of the stages of change across a wide range of health behaviors, from condom use to smoking cessation. According to Maysel Kemp White, associate director of the Bayer Institute, behavioral change occurs in six phases. A smoker, for instance, may show up in your office without any thought of quitting. That's phase 1 (precontemplation).

In phase 2 (contemplation), the smoker is thinking about quitting. He may then prepare for change perhaps by enrolling in a smoking-cessation class or asking you about a nicotine patch (phase 3 - preparation). This may be followed by an attempt to quit (phase 4 - action); a struggle to sustain the change (phase 5 maintenance); and, finally, efforts to integrate the new behavior (phase 6 - termination). These distinctions can help you tailor your intervention to the appropriate stage of change.

"If my patient tells me he doesn't want to stop smoking and doesn't think it's all that important, my goal - in a 20-minute office visit - isn't to get him to quit," says internist Gordon. "It's to help convince him that quitting is important. That's doable."

There's a payoff for you, too. When you look upon change as a process, your goals become more realistic. Helping a patient progress from not thinking about change to thinking about it, for example, constitutes a successful intervention - one you can document on the chart.

"Once you let go of your need to see change all at once, you start to see positive changes in patients very frequently, as they inch toward the larger goal," says FP Richard Brown, associate professor of family medicine at the University of Wisconsin Medical School, who gives regular seminars on motivational interviewing.

Five essential skills in promoting behavioral change

Your understanding that change is a process is an all-important first step. To keep patients moving along the continuum, however, you'll need a reliable strategy. One of these is
motivational interviewing, a series of questions and responses designed to boost incentive and enhance commitment to change.

Strategy alone isn't enough, though. Your outcomes will depend, in large part, on how you relate to patients.

Don't expect good results in the absence of genuine empathy or respect for patients' autonomy, experts say. "If you respect people's right to engage in at-risk behaviors, but point out that they have other options, they're more likely to make healthier choices over time," says Rochester FP Richard Botelho, a motivational [TABULAR DATA OMITTED] interviewing trainer and co-author of an upcoming book series on the subject.

"Accepting behavior without blame and judgment is tough, especially when you know you'll be awakened at 1 a.m. to treat inveterate smokers for respiratory failure," Gordon admits. The payoff, he says, is that it keeps the relationship from becoming adversarial.

In "Motivational Interviewing: Preparing People to Change Addictive Behavior" (Guilford Press, New York), William R. Miller and Stephen Rollnick list five skills they consider most important in fostering positive change

* Empathy.

* Heightening the discrepancy between the patient's present behavior (being cavalier about her diabetes regimen, for instance) and broader goals (staying healthy enough to care for her children).

* Avoiding debate.

* Rolling with resistance.

* Supporting self-efficacy.

Empathy is expressed through a technique called "reflective listening." Suppose the patient says, "I don't have quite as much energy lately. It's really apparent when I'm playing with my grandkids." You might simply reflect back, "So you wish you had more energy for your grandchildren."

One purpose of reflective listening is to make sure you understand what the patient means. Miller and Rollnick say patients experience empathy when they feel they've been heard. The other purpose of reflective listening is to give you an opportunity to reinforce statements the patient makes in favor of change.
Heightening the discrepancy is a way to increase the uneasiness patients feel when they engage in behavior that's inconsistent with their long-term goals. This can move the patient closer to action.

"Here's where we ask, 'What is it like for you to have coronary artery disease, yet continue to engage in behaviors that put you at risk?" says Brown. "We can help the patient weigh the short-term gains of the behavior against the long-term gains of investing energy in change."

One way Botelho approaches this is to ask, "If you developed a complication from smoking, say lung disease, do you think you would quit smoking?" if the patient says Yes, Botelho's next question is: "Do you want to wait until you get a complication to decide to change, or do you want to change now?" If the patient answers the first question with a No, "I respect the answer and ask why." Asking patients why they don't want to change can have the paradoxical effect of bringing them closer to it, says Botelho.

Avoiding debate makes it easier for the patient to work with you. "If you're in an adversarial position, you tend to shift responsibility to the other person," says Gordon. "The patient says, 'I'll lie here; you fix me.' You think, 'Go fix yourself.' You both leave angry."

Rolling with resistance can help you determine why a patient continues to engage in an undesirable behavior or habit. "When patients repeatedly come back with 'Yes, but . . .' it's time to let them explain why they can't comply," says Kemp White. "They're saying, 'This is hard for me.' What they need is someone who can roll with their resistance and say, 'Yeah, you're right. It's tough to lose weight. If that plan isn't working for you, fine. Of all the options we've talked about, let's see what would work.'"

When patients are particularly resistant, Gordon asks permission to return to the topic in the future. 'I've had some patients say, 'Doc, I'm out of here if you ever bring up my smoking again.' I tell them, 'I care enough about your health to want to talk with you about this. Can I have your permission to talk about smoking later, when I can show you new findings that apply to you?'"

Supporting self-efficacy may mean helping the patient remember other challenges he has handled successfully, or drawing on the patient's own problem-solving ability. This is more likely to produce a successful outcome than urging your own solutions.

FP Richard Brown tells of a patient who quit an alcoholic treatment program midway through. "At first I thought he wasn't interested in getting well," says Brown. "But when we explored it, I understood why he didn't like the program. He has a social phobia, and this program required him to speak about very personal issues in front of a group."

Talking it out helped the patient devise a plan that appealed to him: attending Alcoholics Anonymous meetings; confiding only in his sponsor and a few people close to him; and avoiding situations in which he was likely to drink. "It's been 18 months since he joined AA," Brown says, "and he's been able to stay sober."
Putting it into practice one step at a time

If you want to master these techniques, seminars at medical meetings abound. Most run a half-day or a day. (See "Where to learn more," page 107.) The physician-teachers emphasize brief interventions and can give you feedback as you experiment.

Miller and Rollnick's book, on the other hand, is aimed at counselors who have more time to spend with patients. You're likely to find help, however, in the interview transcripts and the chapter on "Brief Motivational Interviewing for Use by the Nonspecialist."

Brown says it took him about six months of working with the techniques to achieve "a basic level of competence." He attended his first workshop six years ago, and has now reached the point where he finds counseling patients on healthier behaviors "a lot of fun."

Here are two exercises to get you started. They're useful whether the patient has trouble sticking to a diet or exercise routine, staying away from cigarettes or alcohol, or adhering to a long-term treatment regimen.

If the patient isn't even considering making an important change, try nudging her in that direction with a decision-balance form (see page 103). First, ask the patient if she'd like to use the form so you can better understand why she doesn't want to change, says Richard Botelho. Then fill it in together. You want to get her thinking about what she gains from her current behavior, what concerns her about it, and how she'd ultimately benefit from making the change.

This exercise "helps you form an alliance with patients in their struggle with change," says Botelho. "It makes the struggle one between the patient and the behavior rather than between the patient and the doctor."

A good way to assess the patient's readiness to change is to use the Confidence/Conviction Scale, developed by Maysel Kemp White and Vaughn Keller for the Bayer Institute's workshop, "Choices and Changes: Clinician Influence and Patient Action" (see page 104).

Ask the patient, "On a scale of 1 to 10, how important is it to you to make this change?" Plot the answer on the grid. Then ask, "On a scale of 1 to 10, how convinced are you that you can do it?" Plot that answer, too.

If the patient has high confidence and high conviction, you might spend a few minutes exploring how he plans to overcome potential obstacles. How might your accountant-patient stick to an exercise routine during tax season? How might a diabetic get through the holidays? You could even assign the question as homework for patients to complete before the next visit.

If the patient has high confidence but low conviction, engage in a dialogue designed to heighten the discrepancy between her desire for good health and the short-term effects of her behavior. Use reflective listening. Keep your words, and your tone, judgment-free.
Let's say the patient is a single mother who's meticulous about making sure her young children get their shots and annual checkups on time. You might ask, "How is it that you place such a high value on health, yet continue to take pleasure in smoking?"

If the patient has low confidence and high conviction, aim to enhance his self-confidence. Again, ask how he's handled a similar challenge in the past. You might say, "I know that your work has required you to make some tough decisions and follow through with them. Can you tell me about a time when you had to implement something very difficult, and succeeded?"

Ask the patient how he might realistically take small steps toward a health goal. Remind him that by taking no action he is, in effect, making a choice.

If the patient has low confidence and conviction, work to build both. Accept the fact that this will take time. You might tell the patient, as internist Geoffrey Gordon does, "When the part of you that wants to change is ready, I'll be there."

**RELATED ARTICLE: Where to learn more**

Specialty society annual conferences are a good place to look for half-day or full-day seminars on motivational interviewing. The spring conference of the Society of Teachers of Family Medicine, for instance, is a good one to consider because it usually offers a couple of sessions on this subject. To inquire, call their program department, 800274-2237, extension 4510. The Web address is www.stfm.org. Abstracts of the 1998 sessions are available at that site.

Another option is The Bayer Institute's workshop, "Choices and Changes: Clinician Influence and Patient Action," which incorporates motivational interviewing along with other research-backed techniques for promoting changes in health behavior. The program was designed with doctors in mind, and most if not all of its trainers are physicians. For a schedule of one-day regional workshops or the weeklong trainer's program, call 800-800-5907 or write to the Bayer Institute for Health Care Communication, 400 Morgan Lane, West Haven, Conn. 06516. Also consider the annual National Wellness Conference, a weeklong summer program held at the University of Wisconsin-Stevens Point. To register or receive a conference brochure, call 800-243-8694. For more in-depth information about conference programs, visit the Web site at www.wellnessnwi.org. Click on "National Wellness Conference" to get to the conference page. Or you can go to the page directly at www.wellnessnwi.org/nwc.

FP Richard Brown, associate professor in the Department of Family Medicine, University of Wisconsin Medical School, is presenting a course at the National Wellness Conference this year. He also teaches an Internet course sponsored by the Addiction Technology Transfer Center of New England (ATTC-NE) at Brown University. Look for information on his course at center.butler.brown.edu/CED/online-courseclist.html. If you have difficulty getting to the page, go to center.butler.brown.edu/ATC-NE/, click on "Online Education," then on "Current Course List." Or you can call Susan Storti, co-director, ATTC-NE at 401-444-1805, or E-mail her at Susan_Storti@brown.edu.
Rochester FP Richard Botelho, who provides organizational training on this topic here and abroad, will lead a seminar on promoting health change behavior at the Fifth International Congress of Behavioral Medicine in Copenhagen, Aug. 19 to 22. E-Mail Botelho at rbotelho@highland.rochester.edu, or check http://socbehmed.org/sbm/Copenhag.htm for more information. Botelho and psychologist Harvey Skinner are the authors of an upcoming three-book series on negotiating change, written expressly for health-care professionals with limited time for counseling.


Although time demands nearly always limit the thoroughness of this process, ideally the provider:

a. Thinks about the psychosocial contexts (patient culture, experience, understanding, ability, environment) relevant to any particular intervention;

b. Seeks new contextual information if there does not seem to be enough;

c. Tries to design and present the intervention so that it is most likely to produce the desired results, given these contexts;

d. Tries to be fully aware of the relevant details (social ambiance of the interaction and who is present, exact vocabulary used, visual cues such as expression, posture, gesture, tone of voice) of interaction with the patient/caretakers concerning the intervention;

e. Asks the patient/caretakers, if possible, to respond with feelings, problems, questions; and to feed back their understanding of the instructions;

f. Adjusts the intervention in the light of any new information;

g. Records enough of these details so that they can be used to evaluate the psychosocial dimension of the outcome later;

h. Seeks information on the psychosocial features of the course and outcome of the problem (compliance problems, unexpected social/economic/environmental consequences) following the intervention;

Examples of the kinds of things one learns {by treating interventions as psychosocial experiments} this way:
- Having a social worker or volunteer make transportation or child-care arrangements often improves the attendance of poor single mothers at appointments.

- If a chronically ill person will not take certain medications, it might be because they have experienced negative emotional or social results. (For example, incontinence resulting from diuretics.) It may work to reduce the dose.

- Teaching an IV drug user how to inject in a more sterile way might spare him repeated abscesses and systemic infections.

- If depression is a complication of a poor patient’s condition, it might help if the patient has an inexpensive way of participating actively in the treatment; for example, by growing and/or preparing certain foods or herbs, by taking up a personally meaningful activity (such as volunteer work) that requires exercise; or by teaching other patients how to deal with a similar problem.

Recognizing and responding to signs of anger in a patient may improve communication and build trust, thereby improving cooperation and outcome.