An Interprofessional Educational Initiative to Empower Health Behavior Change and Improve Health Outcomes

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Introduction

In 1961, Drs, White, Williams, and Greenberg published a seminal paper in the New England Journal of Medicine effectively making the case that the "natural history of a patient's medical care" is a more useful metric than "the natural history of a patient's disease" around which to formulate health policy, drive health care research and care delivery resources allocation, and to serve as an organizing principle for health professional education.

For every 1000 people at risk in a population, White and colleagues identified 750 who will report the occurrence of one or more "illnesses" in a month. Of these, 250 will seek medical provider attention with fewer than 10 requiring hospital admission, fewer than 5 requiring specialty referral, and only 1 requiring admission to an academic health center. [1]

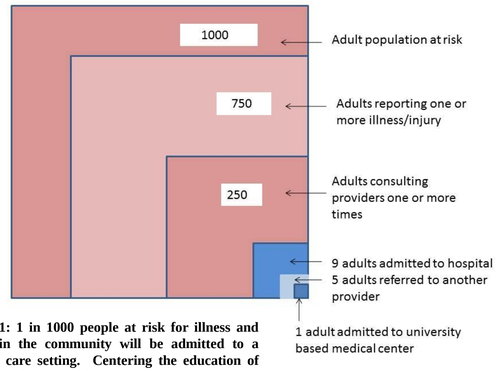

Figure 1: 1 in 1000 people at risk for illness and injury in the community will be admitted to a tertiary care setting. Centering the education of health professionals in tertiary care leads to a skewed understanding of health , health care, and health care outcomes.[1]

Those few numbers of patients represented by the smallest box in the lower right hand corner of figure 1 are substantively different "demographically, socially, and clinically" from those in the wider community, yet health professional education is centered around tertiary care skewing student understanding and perspectives on health, health care, and health outcomes.[1-2]

In a 2014 National Academies of Science workshop " Building Health Workforce Capacity, Through Community-Based Health Professional Education" Warren Newton from the American Board of Family Medicine used this starting point to highlight how the landscape of "medical care" remains essentially unchanged. The question White and colleagues asked in 1961, and reaffirmed by Green et al, in 2001, is still relevant. "Why is so much health profession education centered in tertiary care?" [1-3]

This mismatch between where students learn and the real needs of patients is largely a function of long siloed education models that promote professional independence, static curricula, and an isolated educating culture. When the emphasis is on autonomous and independent practice students don't learn they are "also responsible and accountable for the overall functioning of the health care delivery system". [2-6]

"There is a need to build a shared foundation for health professions education and practice" [6]

After more than 50 years of highlighting the critical link between synergistic interrelationships in health care professions education, best practice, and best outcomes for patients, the IOM called on academic institutions to adopt new Interprofessional team models of educating health professions with a focus on shaping health outcomes. [7]

Not only does teaching students in teams help them learn that they can work together to improve patient care and the processes and systems that support patient care but **team educational strategies must be purposely designed to harness discipline expertise in teams** to assure improved health outcomes for patients and populations.[6-10]

Though each health care discipline brings unique focus and skills to the health care arena one aspect of practice common to all disciplines is the use of purposely designed and strategically deployed education to affect a positive health behavior outcome. Rather than continuing to silo-prepare health professionals to use health education interventions in practice silos, there needs to be a shift in emphasis and in focus to building shared discipline knowledge and skills across a shared curriculum . Centering the building of this team skill set in a shared curriculum best lays the foundation for shared practice.[7-10]

A central tenet of this shift in perspective is the need to recognize the vital role of the direct involvement of individuals, families, and communities in the education-to-practice continuum to help ensure that education, training, and professional development are designed in ways that have a positive impact on health. There also needs to be an acknowledgement that previous and worthwhile efforts to develop models of IPE have not generally been accompanied by significant health system redesign. Change in "one aspect of these interacting systems inevitably influences the other" and any widespread adoption of IPE must occur across an integrated and re-envisioned learning continuum. [9-10]

An IOM summit of thought leaders across the globe assembled and reviewed the evidence in support of new approaches to health professional education for best outcomes . In their insightful summit report they proposed a new conceptual model to shape the next generation of health providers. This model emphasizes both formal and informal longitudinal curricular approaches while acknowledging the forces that enable and interfere with learning and system outcomes[10]

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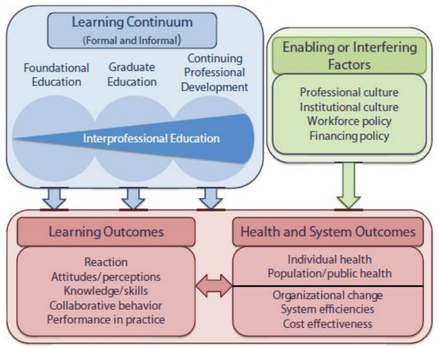

Figure 2: New models of IPE need to recognize that individual and population health outcomes depend on longitudinal approaches to educating health professionals to influence health outcomes within an active system re-design framework. [10]

Building a longitudinal IPE program to develop health education competencies through Community Engagement

We propose a new integrated curriculum using an existing campus wide IPE CIPP course framework that would include students from the schools of medicine, nursing, dentistry, pharmacy, social work, and public health.

Critical to the success of this curriculum would be its centering in the larger community cared for by students and graduates of the University of Maryland professional schools. [10-12]

The education of health professionals to understand how best to inform , support, and guide health behaviors will begin in the first year of each program , building the shared scaffolding of knowledge, attitudes, values, beliefs, and skills necessary across each subsequent year.[11-14]

A pilot program would begin with an introduction to the community and how best to understand the dynamics of the community and engagement in the community. We propose this being centered in the Community Engagement Center (CEC) in our West Baltimore community. Foundational content would include an understanding of what constitutes and motivates health behaviors, providing a framework upon which to build individual and community assessment skills. Level two content would emphasize evidence based approaches to informing and supporting individual health behaviors including a focus on best practice health education interventions. Level three content would include IPE service learning opportunities in the community of focus.[12-16,18]

One critical aspect of this curriculum would be developing the skill sets of individual health professionals in training in the content of community identified health behavior outcomes. [16-17] Such health outcomes could include:

* pediatric oral health
* maternal and newborn health
* adolescent gun violence
* pediatric asthma
* substance use in elders
* childhood weight and exercise

Moving beyond "Sell and Tell"

Next steps

Current models of educating health professionals to engage in health education are siloed within disciplines and oriented to the one way delivery of information to inform health behaviors. Evidence supports more transactional models of health education that explore motivations and empower individuals to engage in health behaviors centered in communities.

We propose a planning group from IPE stakeholders in each professional school to develop a campus IPE seed grant to support curriculum development and to address the logistical challenges to imbedding IPE geared health educator content across existing curricular frameworks. A longitudinal approach to building health education skills through Interprofessional team working in and through community engagement holds the best promise to harness and focus discipline excellence toward better health outcomes.

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