

BUILDING A CULTURE OF COLLABORATION: INTERPROFESSIONAL EDUCATION AND PRACTICE



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It is hard to imagine that for decades the importance of a major public health problem like oral health and its relation to overall health has gone virtually unnoticed in the professional education and practice of physicians, nurse practitioners, midwives, physician assistants, and pharmacists, the most likely health professionals to play a leadership role in advancing patient-centered care.

Identified in *Healthy People 2020* (USDHHS, 2011) as one of the 10 Leading Health Indicators, oral health all too often remains a domain for the professional preparation of dentists and dental hygienists, disconnecting the mouth from the rest of the body as an integral dimension of overall health. In fact, for physicians, nurse practitioners, and physician assistants, even the traditional physical examination of the head and neck acronym, HEENT, does not signify inclusion of the oral cavity in a way that HEENOT would! Using the HEENOT approach means that primary care educators and clinicians CANNOT omit oral health from the assessment, diagnosis, and management of their patients' overall health.

We are at a jumping-off point, a point ripe for ending professional content and practice silos! Publication of recent Institute of Medicine reports (2011a;

2011b), which documented the need to build interprofessional (IP) oral health workforce capacity, provided support for developing interprofessional oral health core competencies for primary care providers. The new *Interprofessional Education Competencies* (IPEC, 2011) and interprofessional accreditation standards for dentistry, nursing, medicine, and pharmacy have created momentum for educators to begin to reach across academic silos. Rapid changes in the healthcare paradigm have been propelled by anticipation of healthcare reform: integrated healthcare delivery systems, accountable care organizations, primary care medical homes, and patient-centered care have all challenged educators and clinicians alike to prepare our graduates to function effectively in this healthcare environment, competent to deliver on the Institute for Healthcare Improvement's (IHI, 2014) "Triple Aim," illustrated in the figure on the next page. As faculty, we need to commit to preparing graduates who are practice-ready to work in teams to improve the patient experience, improve the health of populations, and reduce the cost of health care. Oral-systemic health is poised to become the perfect example of interprofessional competencies in order to build an IP workforce that can actualize the "Triple Aim."

Health professions education programs that are committed to transforming their curricula to develop IP competencies confront multiple challenges at the student, faculty, and organizational levels. Foremost is the organizational challenge for the leader-

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ship of each academic or clinical unit to examine their values about: a) the importance of oral health and the links to overall health, b) the commitment to an IP culture change, and c) the allocation of resources to support building IP infrastructure and curriculum/practice implementation. Signaling support from the leadership team is essential to obtaining internal stakeholder “buy-in” and cultivating IP change champions who will play formal and informal leadership roles. Resource allocation communicates organizational support about faculty interprofessional competency development as a strategic priority.

Another challenge is deciding the number of professions that will participate in IP oral health experiences. Professional egos need to be checked at the door; participants need to assess their IP Teamwork IQ. Making IP experiences “fun” is key to early successes; “wins” are important in sustaining the enthusiasm of early adopters. Engaging a small group of key stakeholder schools or departments as partners is more pragmatic. Because faculty tend to teach and practice the way they were prepared, faculty development is essential. For dental education faculty who most commonly practice in a private practice environment outside of healthcare organizations, it may be a challenge to embrace IP and general health competencies themselves,

much less be role models of them for their students. Nursing and medical school faculty, whose education and

not undermine the “Explicit” IP curriculum, both IP and oral health messaging need to be consistent so that students

have effective IP role models in dental, nursing, and medical classroom and clinical settings. Faculty development is a critical factor in promoting culture change. It promotes relationship

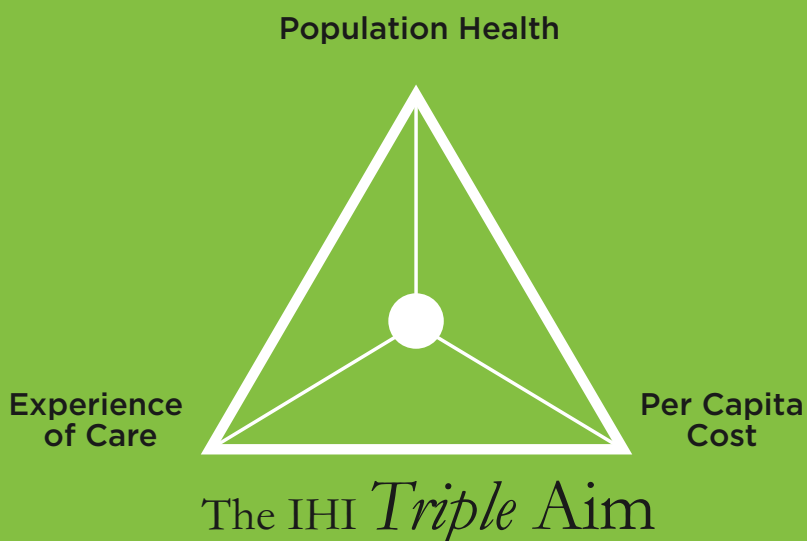
building across the professions, as well as ownership and accountability for the success of the IP initiative(s), in turn creating an IP support network and a critical mass of change champions.

Standardizing the curriculum so that all students are exposed to multiple

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practice reflect a dearth of oral health content and clinical focus, will have to meet the challenge of developing an IP oral health knowledge base and clinical competencies as well as the IP competencies. In order to maximize the likelihood that the “Implicit” IP curriculum does

Institute for Healthcare Improvement’s Triple Aim (adapted diagram)



“doses,” delivered in an incremental, timed sequence across the curriculum, is consistent with the long-term goal of creating an IP oral health culture change, but it represents another IP challenge. Interprofessional initiatives that are intermittent and/or rely on volunteers tend to attract a skewed faculty and student sample of “true believers,” who may become change champions but don’t reflect the organization’s general enthusiasm for or commitment to oral health and/or IP curriculum integration. Faculty are challenged to be innovative facilitators rather than “talking heads” in developing and implementing IP classroom and/or clinical experiences. For decades, we have had students from across the health professions in the same basic science courses, but students typically interact only with members of their own profession. Interprofessional clinical experiences that capitalize on

existing courses, clerkships, and clinical rotations are optimal for weaving oral-systemic health and IP competencies into the curriculum without creating “extra courses or rotations.” They also make a case for clinical com-

petency development which sets the stage for a post-graduation approach to implementing the “Triple Aim.”

In making this paradigm shift, faculty are asked to embrace the role of facilitator and use educational technology to bring students together in virtual and

face-to-face experiences using simulation, standardized patients, virtual cases, telehealth, debates, and service learning experiences, to mention a few options. For example, the Smiles for Life interprofessional, web-based oral health curriculum for primary care providers (www.smilesforlifeoralhealth.com) can be used for faculty development and curriculum integration. The use of technology is also an effective way to engage a generation of students for whom this is a preferred learning modality, as well as a vehicle to transcend the administrator and faculty trauma of conflicting academic calendars and schedules.

The final challenge is to determine how we will know that integrating IP oral health core competencies and/or IP competencies makes a difference in the patient experience, in the quality of population health outcomes, or in the afford-

ability of health care. Evaluation is essential. Health professions schools and faculty must commit to evaluating development of oral health and IP competencies. Use of educational technology, including simulation and the electronic health record, are effective tools for

documenting clinical competencies. Course evaluations with specific and sometimes customized items about the integration of oral health and IP competencies are effective, and there is an array of measurement tools that assess perception of IP competence, attitude change,

and team building. Having an evidence base that indicates we have prepared graduates from dentistry, nursing, medicine, and other health professions who are competent to meet the nation’s IP oral health population health needs is an important outcome.

Data that reveal our graduates continue to use an interprofessional practice framework to positively impact patient experiences, improve population health, and reduce the cost of health care will be the ultimate test of IP effectiveness. As Ryunosuke Satoro wrote, “Individually, we are one drop. Together, we are an ocean.” It is in building a culture of collaboration that we will have a collective impact in interprofessional oral health education and practice.

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