

Making the Business Case for Interprofessional Education and Training

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This issue brief frames a basic business case supporting increased emphasis on interprofessional education and training by academic health centers. It also addresses practical considerations and potential limitations with respect to continued development and implementation of interprofessional education and training programs.

WHAT MAKES ACADEMIC HEALTH CENTERS UNIQUE?

A full appreciation of the business case for interprofessional education begins with the definition of an academic health center. As defined by the Association of Academic Health Centers (AAHC), it is an educational institution that includes a medical school and at least one additional health professions school (e.g., nursing, dentistry, pharmacy, allied health, public health, veterinary medicine, graduate school), and either owns or is affiliated with a hospital or health system.

In the course of carrying out their mission of advancing and applying knowledge to improve health and well-being, academic health centers engage in three essential activities:

- Educating the nation's health workforce through their health professions schools;
- Conducting cutting-edge biomedical and clinical research; and
- Providing comprehensive patient care.

Although they are part of the system of higher education and located within universities, academic health centers engage in clinical activities that extend beyond those of traditional academia. Similarly, although they compete in the healthcare marketplace with for-profit and not-for-profit physician groups, hospitals, and health systems, academic health centers engage in far more extensive educational and research activities than their competitors. In other words, they are

neither purely academic institutions nor purely healthcare providers.

Academic health centers have additional distinguishing characteristics. For example, they frequently serve a disproportionate share of the uninsured and underinsured in their communities, and often have a mission (if not mandate) to serve as provider of last resort. Academic health centers are also more likely to provide tertiary and quaternary healthcare services, specializing in the most complex and difficult diagnoses and treatments.

THE BUSINESS CASE FOR INTERPROFESSIONAL COLLABORATIVE PRACTICE

The business case for interprofessional education and training should not be viewed in isolation, but as part of a causal chain linked to the business case for interprofessional collaborative practice. The convergence of several healthcare system trends suggests that interprofessional collaborative practice is integral to the future of health care. These trends strengthen the business case for academic health centers supporting and promoting interprofessional collaborative practice in their own work settings, and well as in the health system generally:

- Government budget constraints, and employers cost-shifting to employees, will place increasing downward pressure on healthcare reimbursement. Narrowing margins demand greater efficiency and cost-effectiveness in healthcare delivery, including health professionals practicing at or near the full extent of their training when they provide care to patients. This, in turn, requires that care be delivered in multi-professional settings where the type, scope, and extent of care needed can be matched to a health professional with sufficient and appropriate, but not excess, expertise.
- Aging populations, in combination with the social determinants of health that lead to chronic conditions and multiple

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co-morbidities, are consuming an increasing portion of total healthcare expenditures. Effective care management for patients with multiple chronic conditions, as well as those needing behavioral health services, demands effective multi-professional care coordination.

- Emerging evidence that multi-professional teams achieve better outcomes treating a variety of conditions, together with emerging evidence that reducing errors and improving quality requires effective multi-professional collaboration, suggests that interprofessional collaborative practice is a characteristic of learning healthcare systems.
- Although it is sometimes taken for granted that the lack of interprofessional collegiality and disrespectful behavior that compromised some healthcare work settings in the past are behind us, the regrettable truth is that such unprofessional conduct still occurs. With reimbursement constraints and narrowing margins, health systems can no longer afford to absorb the adverse human resource costs of poor interprofessional collaboration and its consequences (e.g., disciplinary and legal proceedings, unnecessarily high staff turnover).

In short, to remain cost competitive, to improve quality and effectiveness in anticipation of value-based reimbursement systems, and to address the evolving healthcare needs of a demographically dynamic patient population, academic health centers (and the healthcare system generally) must make interprofessional collaborative practice a fundamental characteristic of how they organize and deliver care.

MAKING THE ADDITIONAL BUSINESS CASE FOR INTERPROFESSIONAL EDUCATION AND TRAINING

Patient-centered models of care, such as the “medical home,” rely on care environments that are inherently multi-professional. The growing acceptance of patient-centered models of care implies a growing demand for interprofessional collaboration and practice. As the business case for interprofessional collaborative practice strengthens, will the business case for interprofessional education and training strengthen as well?

There are four implicit causal connections which are necessary to establish the business case for interprofessional education and training. The business case can only be made if all four links in the causal chain are valid, or can be made valid through improved alignment of educational curriculum, placements and residencies, accreditation, licensing, scope of practice, reimbursement policies and practice environments. The four connections are:

- That interprofessional education and training increases core competencies in interprofessional collaborative practice;
- That increased competency in interprofessional collaborative practice increases health professionals’ effectiveness in multi-professional care settings (e.g., medical homes, care teams, chronic disease management);
- That effective multi-professional care improves outcomes and quality while lowering long-term costs; and
- That improving outcomes and quality, while lowering long-term costs, is in the financial best interest of the healthcare system, including academic health centers.

Of the four connections, the first has been the weakest link in the causal chain, in large part because there was no consensus definition of core competencies for interprofessional collaborative practice to serve as the foundation for interprofessional education and training programs.

The release in May 2011 of an expert panel report on core competencies for interprofessional collaborative practice¹ provided a missing platform for the design and implementation of more focused and consistent interprofessional education and training programs across academic health centers in the U.S. Similar in scope and vision to core competencies developed by the World Health Organization (WHO),² the May 2011 report is expected to help catalyze interest and activity in interprofessional education and training throughout the U.S.

Additional work is needed to further strengthen the first link in the causal chain. Teaching the core competencies of interprofessional collaborative practice is a fundamentally different challenge compared to teaching clinical competencies. Collaborative practice competencies extend far beyond respectful conduct and include the development of process and systems-based management, leadership, and teamwork skills. Academic health centers’ admissions policies must be involved as well, as the success of interprofessional education and training programs will depend, in part, on the selection of students whose values and skills are most suited to developing collaborative, not just clinical, competencies. Consortia of academic institutions have emerged to help develop best practices in interprofessional education and training programs.³

IMPORTANT CONSIDERATIONS AND LIMITATIONS

Among the unanswered questions about interprofessional education and training, the following two are perhaps the most pressing questions that need to be addressed:

- *Can competency in interprofessional collaboration be taught successfully in an academic setting (as clinical competencies currently are), or is interprofessional collaborative practice a competency that must be learned in a practice environment?* Unlike clinical competencies, which academic health centers have been very successful in teaching, interprofessional

collaborative practice is a more process and system-dependent competency. Best practices in curriculum development and implementation are still in a relatively early stage of evolution and dissemination; it is unclear how effectively these process and systems-dependent competencies can be taught in academic settings.

- *If effective interprofessional education and training proves to be heavily dependent on health professions students and residents gaining first-hand experience in multi-professional collaborative practice settings, does this require a significant reallocation of education and training sites toward settings that feature a greater degree of multi-professional collaboration than typical current placements?* While a number of health systems (e.g., integrated delivery systems, the Veterans Administration health system) emphasize interprofessional collaborative practice, such health systems may not be readily accessible to some academic health centers for placement partnerships. Until interprofessional collaborative practice becomes more widespread, some academic health centers may struggle to identify appropriately collaborative placement settings within their current placement partners.

CONCLUSION

As the healthcare system inexorably demands greater collaboration to more effectively manage patient needs, the business case for interprofessional education and practice will strengthen over time. A primary short-term obstacle to making the business case for interprofessional education and training appears to be overcoming the conundrum of how to find sufficient collaborative practice settings for student placements in a health system where collaborative practice is not yet sufficiently widespread.

References:

- ¹ Interprofessional Education Collaborative Expert Panel. 2011. Core competencies for interprofessional practice: Report of an expert panel. Washington: Sponsored by the Interprofessional Education Collaborative.
- ² See, e.g., the WHO framework for action on interprofessional education and collaborative practice, http://www.who.int/hrh/resources/framework_action/en/index.html.
- ³ See, e.g., the Interprofessional Education Collaborative (IPEC) website, <http://www.une.edu/wchp/ipec/>, launched in May 2011.



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To advance health and well-being through the vigorous leadership of academic health centers.

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To mobilize and enhance the strengths and resources of the academic health center enterprise in health professions education, patient care, and research.

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