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Commentary on ‘State of the Science: Interprofessional Approaches to Aging, Dementia, and Mental Health’

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Introduction

It is expected that, by 2050, there will be 83.7 million adults aged 65 and older in the United States¹ and 1.6 billion world-wide.² Already there exists an unrecognized crisis in dementia and mental health care for this rapidly growing population.³ Further, the workforce with expertise in aging, dementia, and mental health/substance use (MH/SU) continues to decline, contributing to health disparities.³ As noted by both the Institute of Medicine (IOM)⁴ and the World Health Organization (WHO),⁵ interprofessional teams can play an important role in the improvement of population health outcomes for older adults.

Interprofessional teams are not new to geriatrics and gerontology.⁶ Over the past decade, emerging strategies and models of care for interprofessional education and collaboration have built on foundations laid by several organizations.⁴ For example, the WHO generated the widely accepted definition and framework for interprofessional education and collaboration.⁵ For over 50 years, the IOM^{4,7–8} has supported interprofessional education and collaboration and raised awareness of workforce needs for older adults with MH/SU.³ The National Center for Interprofessional Practice and Education⁹ has partnered with the Robert Wood Johnson Foundation,¹⁰ the Josiah Macy Jr. Foundation,⁹ the John A. Hartford Foundation,^{9,11} and the Gordon and Betty Moore Foundation,⁹ to further the work of the Geriatric Interdisciplinary Team Training and Geriatric Interdisciplinary Teams in Practice programs.^{6,9,11} The Partnership for Health and Aging (PHA)¹² developed competencies for geriatrics and gerontology. Finally, the PHA and the American Geriatrics Society¹³ published a position statement to support team training. Yet, despite longstanding and broad support for interprofessional education and collaboration in the care of older adults, physical and mental health disparities persist.

In this supplement, Farrell et al.¹⁴ recommend a unified effort to integrate geriatric and gerontology competencies, content and principles into interprofessional curricula that are aligned with objectives for health systems science.¹⁵ Those objectives aim to transform curricula to improve population health, team-based care, high-value care, leadership, quality improvement, patient safety and health policy.¹⁵ Farrell et al.¹⁴ posit that an intentional, systematic approach by health science educators, health care systems leaders and clinicians is essential to advancing innovation for positive outcomes around aging, dementia and MH/SU.

This manuscript includes a Figure 1 Interprofessional learning continuum (IPLC) model. Permissions were obtained from the National Academies Press for use of this image in the *Journal of American Geriatrics Society*.

Guided by the Interprofessional Learning Continuum (IPLC) model⁴ (see Farrell et al.,¹⁴ Figure 1), this Commentary reinforces and extends the Farrell et al.¹⁴ recommendations by highlighting national and international innovations in interprofessional geriatrics and gerontology, especially related to dementia and mental health. The comprehensive IPLC model grew out of recognition in the IOM's "Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes"⁴ that curriculum reform and collaborative practice redesign are prerequisite to improving health and system outcomes.¹⁶ In that context, this Commentary provides a discussion of curriculum reform, collaborative practice redesign and their linkages to health and systems outcomes^{15,16} and concludes with a brief global perspective¹⁷ on interprofessional education and practice as they relate to aging, dementia and MH/SU in older adults. Innovation exemplars in interprofessional education aim to challenge and stimulate leadership in interprofessional geriatrics and gerontology.

Curriculum Reform

Patient partnerships,¹⁸ interprofessional activities, and workplace learning are all critical foci for interprofessional curriculum reform.⁴ Understanding and embracing the opportunities for culture change in these three areas across health professions will bolster the recommendations by Farrell et al.¹⁴

Patient Partnerships

The Josiah Macy Jr. Foundation¹⁸ has been instrumental in identifying the importance of preparing clinicians to link patients, families, and communities as central and equal members of the interprofessional team,¹⁸ capable of setting their own health care priorities. Equality in patient-provider partnerships helps reduce the stigma around aging, dementia and MH/SU in the older adult population. The 2014 Macy Conference featured a relevant case study from the University of Montreal.¹⁹ Patient and faculty co-facilitated workshops involved health care students in meaningful exercises to better understand the patient experience. By integrating patients as trainers in its interprofessional curriculum, the University's interprofessional education program shifted its focus to patient-provider partnerships.

Interprofessional Activities

The IOM also recommended interprofessional learning activities as part of curriculum reform.⁴ The use of geriatric clinical simulation is widespread^{20,21} and improves the quality of care for older adults.²² Interprofessional simulation activities are more effective than traditional lectures in preparing students for work in collaborative practice settings, especially in the early stages of their training.⁴ For example, participants in a training program in the United Kingdom reported that simulations using patient actors provided valuable learning experiences. The authors noted that while interprofessional communication on dementia care was rarely formally addressed in the curriculum, the simulations built confidence for future collaborative management of agitation and dementia.

20

Developing clinical simulations that incorporate aging, dementia and MH/SU is especially challenging, due to the overlap in medical and psychiatric conditions and symptoms.²³ Unfortunately, there is little guidance in the literature to date on how best to infuse simulation training with principles of essential team-based care in geriatrics and gerontology.²¹

Workplace Learning

Recognition of the value of workplace learning,⁴ is another innovation in curriculum reform.^{4,24} While there are many broad definitions of workplace learning, the IOM describes it as informal, serendipitous learning that occurs spontaneously in every-day practice.⁴ Workplace learning can be applied to learners as individuals, groups, organizations and interprofessional teams.^{25,26} It is an innovation in curriculum that intersects interprofessional continuing education (CE) and lifelong learning (a construct of CE) that occurs at the point of care.²⁷ Point of care learning refers to knowledge that is gained during the patient/health professional encounter.²⁷ Because workplace learning is informal, occurring outside of the academic curriculum and setting, there has been reluctance to incorporate it early in the IPLC model.⁴

Instead of placing CE in the hands of separate discipline-specific regulatory bodies and pharmaceutical and other business sponsors, the IOM recommends a move toward embracing Continuing Professional Development (CPD), i.e., the deliberate collaboration among higher education, formal CE and workplace learning.^{24–26} CPD is a model that can be structured to include all members of the interprofessional team as learners. Further, instead of calculating hours spent attending professional conferences, there is greater accountability when CE credits are earned through documentation of practice change or improvement.²⁴ Thus, CPD involves evaluation of workplace outcomes such as patient safety, reduced costs and provider retention. While CPD is emerging in the US, it is a familiar model in Canada, New Zealand and Europe.²⁴ Adoption in the US is challenged by the need to coordinate interprofessional academic, CE and workplace learning within a national regulatory and accreditation framework.²⁴

Optimizing interprofessional education will require health science educators to use innovative models and think outside the box. Workplace learning shifts the emphasis from learning interprofessionally to working interprofessionally²⁶ and capitalizes on the kinds of stimulating, spontaneous experiences that arise from routine practice as adjunct to traditional academic models. Workplace learning activities hold untapped potential²⁶ to motivate both creative engagement in learning as well as the integration of aging, dementia and mental health into interprofessional education.

Collaborative Practice Redesign

Collaborative practice redesign that is aligned with the Quadruple Aim²⁸ (described below) is also essential to meet the previously mentioned health systems science objectives including improving population health, team-based care, high-value care, leadership, quality improvement, patient safety and health policy.¹⁵ Considering new forms of precepting that improve team-based care will in turn maximize positive outcomes in leadership and

population outcomes. Health reform that considers incentives for team-based care is also a pathway to high-value care.

Quadruple Aim

Evaluation of the impact of collaborative practice has traditionally been measured against: the patient experience, population health and health care costs.^{16,28} Recognition that the well-being of providers and staff is also essential to high-quality outcomes led to addition of a fourth outcome; the workforce (provider and staff) experience.²⁸ Although contemporary models that integrate the four outcomes are still in the early phases, these outcomes now constitute the Quadruple Aim for high-quality care and a collaborative workforce.

Interchangeable Precepting

“Interchangeable precepting”¹⁶ is another innovative strategy for modeling interprofessional competencies in values/ethics, communication, roles and responsibilities, and teams and teamwork.^{29,30}

The four interprofessional competency domains are held in common by members in all disciplines.³¹ Currently, most disciplines still require that students be precepted in the field by a professional in their own discipline. Professional development to enhance interprofessional education and collaboration, however, can provide preceptors with the skills for supervising and preparing students from any discipline to meet the core interprofessional competencies. Two examples may provide clarification. A physical therapist may draw on experiences from rehabilitation to train dentistry students to meet competencies in team and teamwork. An audiologist might serve as an interchangeable preceptor to help social work students achieve competencies in interprofessional communication.

Successful interchangeable precepting requires an interprofessional practice setting with a well-organized infrastructure to integrate formal academic curricula and informal workplace learning opportunities. Revised processes for accreditation, licensure and certification that consider interprofessional collaborative practice competencies³¹ would foster an interchangeable precepting learning environment and the development of a highly competent community of professionals. A widened pool of preceptors will facilitate exchange between academic faculty, workplace providers, patients, students and all members of the interprofessional team to share expertise and experiences in geriatrics and gerontology.

Health Care Reform

Ongoing health system reform in the US has emphasized a broader view of preventive care and wellness.¹⁸ For example, the Josiah Macy Jr.¹⁸ and the Robert Wood Johnson Foundations¹⁰ are promoting integration of patients, families and communities into a culture of health to improve population health outcomes. At the systems-level, policy-makers are moving toward values-based care.^{32–34} The Medicare Access and CHIP Reauthorization Act (MACRA)’s Merit-based Incentive Payment System (MIPS), due to launch in 2019,³² will base payment on the quality of outcomes rather than the quantity of services provided. New models of care include payment for interprofessional teams.³⁴ Ideally, the interprofessional

team will share responsibility for the care of older adults, resulting in better outcomes and a more efficient system with reimbursement based on quality outcome measures.

Funding priorities are critical to advancing health reform. The core federal policy priorities from the American Geriatrics Society recommend expanding and improving Titles VII and VIII Geriatric Health Professions Programs as well as increasing support from other federal mechanisms.³³ Farrell et al.¹⁴ describe how funding from Health Resources and Services Administration and the Geriatric Workforce Education Program (GWEP) plays an important role in leadership development and mental health competencies. In addition, research funding from the Graduate Medical Education, the Veterans Administration and the National Institute on Aging³³ provides critically important resources for advancing interprofessional workforce collaboration in geriatrics and gerontology. Reforming health care payment systems will reduce cost and drive new models of care utilizing interprofessional teams.

Global Perspective on Interprofessional Education and Practice

This final section extends the scope of the Farrell et al.¹⁴ white paper to include a brief global perspective on interprofessional education and practice. Around the globe, the population of adults over 60 years of age has reached 900 million;³⁵ the most common mental disorders among this group are dementia and depression, both of which have high mortality rates. Dementia occurs in 50 million older adults³⁶ and is the 7th leading cause of death worldwide.³⁷ An estimated 15% of all older adults have a mental disorder,³⁵ and the highest rates of suicide are among adults over 70 years old.³⁸ Global strategies³⁶ are sorely needed to enhance quality of life, reduce mortality and caregiver burden and develop new models of care for suicide prevention in older adults.³⁹

The statistics on the international mental health workforce are likewise disturbing. For half of the world's population, there is only one psychiatrist for every 200,000 people^{17,40} and there are great disparities across nations; many countries do not keep any record of mental health providers.⁴¹ Especially outside of China, India, Brazil and the US, half of the countries in the world have 0 to 1 medical schools(s).⁴² Unfortunately for much of the world, health care options for older adults have remained stagnant.

According to the 2010 Lancet Commission, the doubling of the lifespan during the 20th century is attributed to the preparation of health professionals by university-based schools. To meet 21st century challenges in healthcare, the Commission embraced 20th century science-based curricula and the introduction of problem-based instructional innovations. For the next generation, however, the Commission adopted a global perspective and called for a systems-based approach to use global knowledge and professional competencies and thereby improve the performance of health systems. The Commission⁴² supported unified ongoing efforts to build global capacity and proposed a framework for global healthcare design connecting education and health systems to achieve worldwide health equity. Further, the Consortium of Universities for Global Health developed Interprofessional Competencies for Global Health in 2013 in an effort to standardize curricula for academic programs.⁴³

Within this connecting framework, transformation best occurs when every country relies upon learning through educational interdependence and international networks of health systems. Reflecting the impact of global aging and interdependence of education systems, faculty from Norway, Canada and the US⁴⁴ partnered with universities to implement an international interprofessional education experience on teamwork and patient centered care for older adults. Compared with the rest of the world, federal governments from these countries have shown a higher investment in interprofessional education. Out of this collaboration, a hybrid course was developed that included reflections with assignments and presentations on problem solving and problem-based learning.⁴⁴ Students also traveled to participate in face-to-face learning. Results from evaluations showed a positive response generated by international interprofessional collaboration on international priorities due to the impact of global aging on the health and social care systems.⁴⁴

Conclusion

In its 2006 Report,⁴⁵ WHO called for efforts to “work together through inclusive alliances and networks---local, national, and global---across health problems, professions, disciplines, ministries, sectors, and countries.”(p.151) Implementing the Farrell et al.¹⁴ recommendations specific to geriatric and gerontology competencies, principles and content is vital to support innovations in interprofessional education and collaboration at local, national and international levels. Continued progressive leadership will be required to transform the current efforts in curriculum reform, collaborative practice redesign, patient and community partnerships, health care systems reform and global vision from mere echoes of the past to a new reality.

Over the past decade, for example, health care professionals from various disciplines have made innovative contributions to interprofessional education and collaboration. Visionary nursing leaders developed geropsychiatric nursing competency enhancements^{46,47} that are incorporated into interprofessional curricula. Geriatric mental health learning objectives for medical students are a more recent development that address normal aging, mental health assessment, psychopharmacology, delirium, depression and dementia.⁴⁸ Policy makers are active in creating health systems reform that employ the annual wellness visit and a new payment system for incentivizing interprofessional teamwork.³²⁻³⁴ Global interprofessional competencies,⁴³ models and policies are beginning to facilitate a world-wide shift toward healthcare equity for older adults. These are all broad positive changes that must be incorporated into efforts focused on aging, dementia and mental health. For those who are passionate about geriatrics and gerontology, changes may seem too little and too late. A building revolution and commitment to interprofessional education and collaboration, however, promises to accelerate the pace of healthcare transformation world-wide in the 21 century.

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