EASTERN MAINE MEDICAL CENTER
EMHS MEMBER

Welcome to the Interprofessional Education Initiative!

The Interprofessional Education Initiative is designed for students to work with different modalities and develop an appreciation and knowledge of other health professionals' roles. During your rotation with Family Medicine, you will be asked to go on two or more community-based home visits. You will be informed of the dates at the start of your FM rotation.

This folder contains hardcopies of the forms you will use on your community visit. The necessary forms include:

- Home Visit Form
- Interprofessional Self-Reflection Tool

A link will be sent to your email the Monday before your scheduled home visit. The URL provided will connect you to the IPE initiative orientation video (http://youtu.be/2zkQ0f3sluk). I encourage you to watch it now to familiarize yourself with the initiative. You may also access the IPE calendar here:
http://buzzbox.emh.org/members/emmc/EMMC_Reporting/MEW/SitePages/IPE%20Calendar.aspx

Additional resources have also been provided to assist you in your IPE journey. Please find a list of Frequently Asked Questions and contact information for individuals involved in this program that are here to help you and answer any questions you may have along the way. There is a brief overview of the program that will help you learn more about the initiative in the "Core Competencies for Interprofessional Collaborative Practice" handout.

The Home Visit form is from the family practice center, and a copy will be sent to you via email. If you need assistance with the form please contact your preceptor for further instruction.

Lastly, the Interprofessional Self-Reflection Tool needs to be filled out and emailed back to me the same day as the visit at fabailey@emhs.org. The form is a reflection of yourself and your team member's personal and professional experiences on your community visits. The information you provide in the last three questions will be reviewed during the debrief meeting with Interprofessional Education Faculty and the fourth question will be shared directly with the other students on the home visit team. During this meeting we will discuss your home visit, what you learned from the other team members, and program feedback; attendance is mandatory at the IPE debrief. Please read the instructions and contact me at the below phone number if you need further assistance.

Best of luck on your visits!

Frank Bailey, M.Ed.
Medical Educator
Eastern Maine Medical Center
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Bangor, ME 04402-0404
Phone: (207) 973-9060

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All materials can be found online at the Medical Education Sharepoint IPE website.

For any further questions, please feel free to contact Frank Bailey at fabailey@emhs.org

Interprofessional Education Initiative

Family Medicine Contact List

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Interprofessional Education Initiative
Contact List

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Heather is the facilitator accompanying you on the IPE community-based home visit. Her primary roles are to facilitate the flow of communication for IPE home visits and complete outreach to identified candidates for introduction to the IPE concept.

Amy Ludwig is an Administrative Assistant for the Community Care Team. Amy creates the community-based home visit schedules for Tuesday and Thursday. Amy can be contacted Monday midmorning to early afternoon if you have not received patient information or visit information (pre-meeting time, patient visit times, MR information, etc.).

Katie Petersen

Medical Education Specialist

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kpetersen@emhs.org

Katie Petersen is a Medical Education Specialist for EMMC's Medical Education Department. She coordinates the IPE meetings and schedules the debrief sessions.

Frank Bailey, M.Ed.

Medical Educator

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fabailey@emhs.org

Frank Bailey is the Medical Educator for EMMC's Medical Education Department. His role in the Interprofessional Education Initiative is facilitating the debrief meeting on Friday mornings, emailing students IPE forms, collecting survey data, and orientating medical students to the program.

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Core Competencies for Interprofessional Collaborative Practice

- Work with individuals of other professions to maintain a climate of mutual respect and shared values.
- Use the knowledge of one's own role and the roles of other professions to appropriately assess and address the health care needs of the patients and populations served.
- Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to maintain health and treatment of disease.
- Apply relationship-building values and the principle of team dynamics to perform effectively in different team roles to plan and deliver patient/population-centered care that is safe, timely, efficient, effective, and equitable.

Student Goals for Interprofessional Education Visits

- Professionally socialize with future health professionals by delivering Interprofessional collaborative care that is timely and consistent in quality.
- Develop an action plan.
- Develop an understanding of the roles and responsibilities for collaborative practice between health professionals.
- Learn how to effectively communicate with others.
- Learn how to work as a team member, and how to practice team-based care.

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American Association of Colleges of Nursing

aacom AMERICAN ASSOCIATION OF COLLEGES OF OSTEOPATHIC MEDICINE

ASPH

American Association of Colleges of Pharmacy AACP

ADEA AMERICAN DENTAL EDUCATION ASSOCIATION

AAMC Tomorrow's Doctors, Tomorrow's Cures®

Core Competencies for Interprofessional Collaborative Practice

Sponsored by the Interprofessional Education Collaborative*

Pre-publication recommendations from the IPEC Expert Panel

February 2011

*IPEC sponsors:

American Association of Colleges of Nursing

American Association of Colleges of Osteopathic Medicine

American Association of Colleges of Pharmacy

American Dental Education Association

Association of American Medical Colleges

Association of Schools of Public Health

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Team-Based Competencies: Building a shared foundation for education into clinical practice

IPEC and the expert panel to develop competencies for interprofessional collaborative practice appreciate the support of the Health Resources and Services Administration, Josiah Macy Jr. Foundation, Robert Wood Johnson Foundation, and ABIM Foundation in sponsoring this conference to use the recommendations of the expert panel as a stimulus for discussion of the core issues surrounding preparation for interprofessional, collaborative practice.

The goals for this conference are to:

- Examine a set of foundational competencies to guide the professional socialization of future health professionals in delivering interprofessional collaborative care that is timely and consistent in quality.
- Assess the relevance of these core competencies for the current practice of interprofessional team-based clinical care and identify any significant gaps.
- Develop an action plan to catalyze the widespread implementation of these competencies in health professions education and practice including identification of critical opportunities and challenges.

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BACKGROUND

Interprofessional Education Collaborative (IPEC)

In 2009, six national education associations of schools of the health professions (AACN, AACOM, AACP, ADEA, AAMC, and ASPH) formed a collaborative to promote and encourage constituent efforts that would advance substantive interprofessional learning experiences to help prepare future clinicians for team-based care of patients.

To help guide educational programs and stimulate joint learning in the six professions, the collaborative convened an expert panel, with two appointees from each association, to recommend a set of core competencies that will lay the foundation for interprofessional collaborative practice.

The panel began its work by reviewing all relevant statements on interprofessional competency previously developed by organizations in the United States and Canada, as well as by international groups and agencies.

Interprofessional Education Collaborative Partners

American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Dental Education Association
Association of American Medical Colleges
Association of Schools of Public Health

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IPEC EXPERT PANEL RECOMMENDATIONS

Core Competencies for Interprofessional Collaborative Practice

The panel's recommendations are available to serve as the stimulus for dialogue and development of an action plan to catalyze the widespread implementation of these competencies in health professions education and practice, with particular focus on opportunities for and challenges to implementation.

Interprofessional Competency Domains

The panel identified four core competency domains that draw meaning from the specific contexts of patient care. Development and demonstration of these competencies require reflection, flexibility, and adaptability to the spectrum of care contexts – from prevention and health maintenance to acute, chronic, long-term, and palliative care – and the overall goals of care in specific situations. These competencies are a key adjunct to the general professional competencies of the individual health professions.

- Values/Ethics for Interprofessional Practice
- Roles/Responsibilities for Collaborative Practice
- Interprofessional Communication
- Interprofessional Teamwork and Team-based Care

Competency Sets

Competency statements were drafted to include the following properties: relationship-centered, process-oriented, able to be integrated through the learning continuum, applicable across practice settings and professions, stated in "common language," patient-centered, outcome driven. Graduates of health professions programs should be able to demonstrate ability to perform each competency in the context of patient care and population health.

Interprofessional Collaborative Practice Core Competency Domains

The Learning Continuum

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Values/Ethics for Interprofessional Practice

Work with individuals of other professions to maintain a climate of mutual respect and shared values.

- Place the interests of patients and populations at the center of interprofessional health care delivery.
- Respect the dignity and privacy of patients while maintaining confidentiality in the delivery of team-based care.
- Accept and embrace the cultural diversity and individual differences that characterize patients, populations, and the health care team.
- Recognize and respect the unique cultures, values, roles/responsibilities, and expertise of other health professions.
- Work in cooperation with those who receive care, those who provide care, and those who contribute to or support the delivery of prevention and health care services.
- Develop a trusting relationship with patients, families, and other team members (Canadian Interprofessional Health Collaborative 2010).
- Demonstrate high standards of ethical conduct and quality of care in one's contributions to team-based care.
- Manage ethical dilemmas specific to interprofessional patient/population-centered care situations.
- Act with honesty and integrity in relationships with patients, families, and other team members.
- Maintain competence in one's own profession appropriate to scope of practice.

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Roles/Responsibilities for Collaborative Practice

Use the knowledge of one's own role and the roles of other professions to appropriately assess and address the health care needs of the patients and populations served.

- Communicate one's roles and responsibilities clearly to patients, families, and other professionals.
- Recognize one's limitations in skills, knowledge, and abilities and engage others when appropriate.
- Engage diverse health care professionals who complement one's own professional expertise, as well as associated resources, to develop strategies to meet specific patient care needs.
- Explain the roles and responsibilities of other care providers and how the team works together to provide care.
- Use the full scope of knowledge, skills, and abilities of available health professionals and health care workers to provide safe, timely, efficient, effective, and equitable care.
- Communicate with team members to clarify each member's responsibility in executing components of a treatment plan or public health intervention.
- Forge interdependent relationships with other professions to improve care and advance learning.
- Engage in continuous professional and interprofessional development to enhance team performance.
- Use the unique and complementary abilities of all team members to optimize patient care.

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Interprofessional Communication

Communicate with patients, families, communities, and other health professionals in a responsive and responsible manner that supports a team approach to maintaining health and treatment of disease.

- Choose effective communication tools and techniques, including information systems and communication technologies, to facilitate discussions and interactions that enhance team function.
- Organize and communicate information with patients, families, and health care team members in a form and format that is understandable, avoiding discipline-specific terminology when possible.
- Express one's knowledge and opinions to team members involved in patient care with confidence, clarity, and respect, and work to ensure common understanding of information, treatment, and care decisions.
- Listen actively and encourage the ideas and opinions of other team members.
- Give timely, sensitive, instructive feedback to others about their performance on the team, and respond respectfully as a team member to feedback from others.
- Use respectful language appropriate for a given difficult situation, crucial conversation, or interprofessional conflict.
- Recognize how one's own uniqueness, including experience level, expertise, culture, power, and hierarchy within the health care team, contributes to effective communication, conflict resolution, and positive interprofessional working relationships (University of Toronto 2008).
- Communicate consistently the importance of teamwork in community and patient-centered care.

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Interprofessional Teamwork and Team-based Care

Apply relationship-building values and the principles of team dynamics to perform effectively in different team roles to plan and deliver patient/population-centered care that is safe, timely, efficient, effective, and equitable.

- Describe the process of team development and the roles and practices of effective teams.
- Develop consensus on the ethical principles to guide all aspects of patient care and teamwork.
- Engage other health professionals – appropriate to the specific care situation – in shared patient-centered problem solving.
- Integrate the knowledge and experience of other professions – appropriate to the specific care situation – to inform care decisions, while respecting patient and community values and priorities/preferences for care.
- Apply leadership practices that support collaboration and team effectiveness.
- Actively engage self and others to identify and constructively manage disagreements about values, roles, goals, and actions that arise among health care professionals and with patients and families.
- Share accountability appropriately with other professions, patients, and communities for outcomes relevant to prevention and health care.
- Reflect on both individual and team performance improvement.
- Use process improvement strategies to increase the effectiveness of interprofessional teamwork and team-based care.
- Use available evidence to inform effective teamwork and team-based practices.
- Perform effectively on teams and in different team roles in a variety of settings.

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Selected Resources

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Core Competencies for Interprofessional Collaborative Practice Panel Roster

(Panel Chair) Madeline Schmitt, Ph.D., R.N., F.A.A.N., Professor Emerita (of Nursing), University of Rochester

Sandra Carlin Andrieu, Ph.D., Professor and Associate Dean for Academic Affairs, Louisiana State University Health Sciences Center School of Dentistry

Amy Blue, Ph.D., Assistant Provost for Education and Professor of Family Medicine at the Medical University of South Carolina

Thomas A. Cavalieri, D.O., F.A.C.O.I., F.A.C.P., Dean, Endowed Chair for Primary Care Research, Professor of Medicine, University of Medicine and Dentistry – New Jersey-School of Osteopathic Medicine

Jane Marie Kirschling, D.N.S., R.N., F.A.A.N., Dean, University of Kentucky College of Nursing

Kathleen Ann Long, Ph.D., R.N., F.A.A.N., Dean, University of Florida College of Nursing

Susan Mackintosh, D.O., M.P.H., Director of Interprofessional Education, Western University of Health Sciences and Assistant Professor, College of Osteopathic Medicine of the Pacific-Department of Social Medicine and Healthcare Leadership

Susan Meyer, Ph.D., Associate Dean for Education, University of Pittsburgh School of Pharmacy

Daniel Robinson, Pharm.D., F.A.S.H.P., Dean, College of Pharmacy, Western University of Health Sciences

Leo E. Rouse, D.D.S., F.A.C.D., Dean, Howard University College of Dentistry

Andrew A. Sorenson, Ph.D., Chair, Institutional Self-Study Task Force, University of South Carolina School of Medicine (affiliation at time of panel appointment)

Thomas R. Viggiano M.D., M.Ed., Associate Dean for Faculty Affairs, Professor of Medical Education and Medicine, Mayo Medical School

Deanna Wathington, M.D., M.P.H., F.A.A.F.P., Associate Dean for Academic and Student Affairs, Office of Academic and Student Affairs, University of South Florida College of Public Health

Staff support was provided by Alexis L. Ruffin, M.S., Director, Medical Education, at the Association of American Medical Colleges.

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CCT Eligibility for IPE Referral

Standing Protocol for IPE/Hospital to Home Referrals to the Community Care Team (CCT)

Designated Center for Family Medicine (FMC+R) and Community Care Team personnel are authorized through this standing protocol to notify the Community Care Team (CCT) for any patient meeting the CCT and IPE/Hospital to Home referral criteria and the following clinical factors:

- A discharge from a hospital and/or SNF other facility within the prior 30 days.
- 11+ medications
- 3 or more ER visits in the past 6 months
- 3 or more hospital admissions in the past 6 months
- A chronic condition not at goal
- Patient has a barrier that is impairing their self-management of a chronic condition

The practice/CCT designee will send a flag in the Electronic Health Record to the Provider and the Team RN to update them that CCT outreach and/or IPE/Hospital to Home visit will be made.

Work Flow is as follows:

1. CCT Lead/Designee reviews daily discharges and screens eligibility for CCT/IPE.
2. CCT sends notification to RN Care Coordinator, CCT Intake, and CCT/Practice Assigned Social Worker.
3. Social Worker completes and documents brief chart review to select priority for IPE visits.
4. Social Worker notifies CCT Intake of priority patients.

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5. CCT Intake schedules IPE visits for designated times, including CCT SWK and/or CCT RN, Medical Residents, Medical Students, and Pharmacy Students.
6. IPE visits completed.
7. All documentation from visit is routed to CCT for documentation/reporting purposes, and it is clear if there will be ongoing CCT intervention or discharge from CCT following IPE visit.
8. CCT logs visits, monitors and reports data related visits.
9. CCT Intake scheduled remaining patients for RN in Hospital to Home capacity.
10. CCT Intake follows all other current protocols related to outreach and discharge when contact with patient does not occur easily.

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What is the Community Care Team?

CCT GOAL – To join with Practice PCP's, doctors, nurses, health educators, nurse care managers to form a home-visiting team that addresses a wide range of barriers to good health. We are connecting patients to resources and providing support. We help patients overcome emotional, social, or physical barriers to receiving care. Having a social worker on the team encourages patients to talk about more than their medical issues and discuss other factors that may cause the need for hospital care.

Social work services include but are not limited to:

- Patient assessment of social/emotional needs
- Evaluation of home environment
- Mental health diagnostic assessments
- Crisis intervention
- Provide brief counseling
- Act as a liaison between patients and the medical team
- Case management
- Assist patients with managing & adjusting to physical changes: normalizing a new lifestyle
- Social workers reinforce the behavior changes, and/or the interventions and preventions recommended by the medical staff.
- Health education – explaining the disease and its treatments to pts in a manner that is sensitive to their literacy levels.

The CCT RN is responsible for preventative services and guiding behavior change; this can be done by reinforcing the behavior changes and/or prevention that has been established by the healthcare provider. In addition, the RN can set in motion behaviors changes that will lead to optimal health.

Registered Nurse services include but are not limited to:

- Health Assessment
- Medication Reconciliation/Education
- Support and guidance in establishing patient centered goals
- Education and support with chronic illnesses, promoting patient self-management skills, e.g. Diabetes, COPD, CHF, CAD, Hypertension, Obesity, Smoking
- Home safety evaluations
- Connecting patients to health resources e.g. diabetes education, pulmonary rehab, Living Well or Chronic Pain Programs, exercise programs, smoking cessation.
- Education in appropriate use of Emergency Room, Urgent Care & Providers.

CCT does home visits to help the Practice better understand the day-to-day circumstances of patients. For many patients, health success requires more than medical care. The overarching goal of the CCT Program is to provide intensive support & work with patients to improve chronic care & reduce health risks.

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Interprofessional Education Reflection Tool Expectations

The Interprofessional Education Reflection Tool is an important instrument used to assess the successfulness of the community-based home visit. The form is an indicator of how effectively the team worked together and learned from each other. Feedback is an essential tool for the growth of an individual personally and professionally. The IPE initiative values performance-based feedback because it enables students to reinforce good habits and correct behaviors non-conducive to optimal team function. Feedback can help gauge current performance and by used to create an action plan for improvement. The IPE initiative expects student's to express positive and negative constructive feedback in a professional manner. This is a growth opportunity and participants should provide objective not subjective feedback.

The students who venture out together on a community-based home visit are required to participate in a pre- and post- debrief meeting (mandatory participation). These meeting will be held at FM on Union Street and a date and time for the pre-meeting will be sent before the visit. The post-debrief-meeting will be held upon return to Family Medicine. The point of the meeting is to recap observations from the visit(s) and express observations, experiences, and perceptions.
During the visit if there is anything seen that is concerning, please contact your preceptor to discuss the issue. The student should also write up his or her concerns and email the information along with the Interprofessional Education Reflection Tool to fabailey@emhs.org.

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Interprofessional Education Reflection Tool

Students are asked to reflect on their personal and professional development by reflecting on their participation in the IPE (Interprofessional Education Initiative) program. Your input will be considered during your evaluation. The forms need to be filled out and sent back the evening of your home visit – please keep in mind that this is a professional document and any comments will be treated as such.

Name: _____ **Home Visit Date:** _____

1 Low Level	*2 Average*	*3 High Level*	*Instructions* *Please read the following questions. Rate your current level of experience with each statement (1 = Low Level; 3 = High Level).* ***Please reflect on each question and briefly describe your performance and the performance of your team members while participating in the IPE program.*** *Please use a different color font when filling out this form.*
			Provide an example of how you contributed to a positive climate by participating actively, working effectively with others, and showing respect and consideration for preceptor, providers, peers, patient, and others. *(Please record your response in the space provided.)*
			Provide an example of how you communicated effectively with team through oral or written language before, during, and after the community visit(s). *(Please record your response in the space provided.)*
			Provide an example of how you solicited and received feedback related to program and professional goals in a positive manner and making necessary adjustments. *(Please record your response in the space provided.)*

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1 Low Level	*2 Average*	*3 High Level*	*Instructions* *Please read the following questions. Rate your current level of experience with each statement (1 = Low Level; 3 = High Level). Please reflect on each question and briefly describe your personal or professional experience with the IPE program. Please use a different color font when filling out this form.*
			Provide an example of how you gave and received help, accepted direction, and respected coworker's contributions. *(Please record your response in the space provided.)*
			Provide an example of how you were sensitive to community and cultural norms by using language demonstrating sensitivity to other; communicating effectively with the team and showing awareness of context in which interactions take place. *(Please record your response in the space provided.)*
			Provide an example of how you valued the development of critical thinking, independent problem solving, and performance capabilities in self and others. *(Please record your response in the space provided.)*

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Interprofessional Education Reflection Tool

Questions 1 thru 3 will be discussed in the public debriefing. Question 4 will not be discussed in the public debriefing, but the feedback will be shared with your counterparts.

1. Please identify areas of strength and areas that require growth within the IPE program.

2. Please list at least two concerns or questions you would like to discuss pertaining to IPE at the debriefing.

3. The Interprofessional Education Initiative is designed for students to work with students from different healthcare professions and develop an appreciation and knowledge of the other professions' roles. A key part of this experience is giving feedback to the other students on their performance. Feedback can provide useful information indicating what the student's strengths are or areas needing some improvement. Please provide any feedback on your observations, experiences, perceptions and thoughts guided by the IPE Initiative – this is to be discussed at the IPE debrief.

4. The IPE initiative values performance-based feedback because it enables students to reinforce good habits and correct behaviors non-conducive to optimal team function. Feedback can help gauge current performance and be used to create an action plan for improvement. The IPE initiative expects students to express positive and constructive feedback in a professional manner. This is a growth opportunity and participants should provide objective not subjective feedback.
Please name one thing you and one thing each other student could do to improve performance on future visits – this will be shared with the other students on your IPE team.

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Modified McMaster-Ottawa scale for rating teams			
	Individual rating		
Competencies	**Below Expected**	**At Expected**	**Above Expected**
Communication (with patient)	1	2	3
Members demonstrate assertive communication			
Members demonstrate respectful communication			
Members demonstrate effective communication			
Collaboration (within the team)	1	2	3
Establishes collaborative relationships			
Integration of perspectives			
Ensures shared information			
Roles and responsibilities	1	2	3
Members describe roles and responsibilities			
Members share knowledge with each other			
Members accepts to one another accountability			
Collaborative patient-family centered approach	1	2	3
Members seek input from patient and family			
Members share information with patients and family			
Members advocate for patient and family			
Conflict management/resolution (within the team)	1	2	3
Members demonstrate active listening			
Members share different perspectives			
Members work w/ each other to prevent conflict w/ one another			
Team functioning	1	2	3
Members evaluate team function and dynamics			
Members contribute effectively			
Members demonstrate shared team function leadership			
Global rating score	1	2	3

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Modified McMaster-Ottawa scale for rating teams

Scoring instruction to rater: Observe the team interaction at the pre- and post-encounter huddle and the patient encounter. Do not interrupt the team. Using the 3-point scale, assess the team's performance (regardless of the individuals' performance) in each of the six competencies and provide an overall/global score based on all these factors.

Detailed explanation of team behaviors for each category:

Communication:
Above expected: (The team) provides comprehensive information about the purpose of the encounter and its findings; anticipates the patient's questions by asking for questions; addresses concerns and answers questions directly; is explicit about conversations among the members; and includes the patient in those discussions.
At expected: provides basic information about the purpose of the encounter; respectfully addresses the patient's questions when initiated by the patient; and includes the patient in its discussions.
Below expected: fails to inform the patient of its actions and intentions; talks down to the patient and/or avoids dialog even when questioned by the patient; ignores the patient when conversing with one another.

Collaboration:
Above expected: (The team) recognizes disagreements and acts to reach consensus so that the patient perceives a unified approach.
At expected: is able to reach agreement by discussing issues in the patient's best interests.
Below expected: is unable to reach agreement on at least half the issues prior to or after the patient encounter.

Roles and responsibilities:
Above expected: (The team) members actively solicit information about one another's roles before the patient encounter.
At expected: members check in when a misunderstanding about one another's roles occurs.
Below expected: members act on mistaken assumptions about one another's roles.

Collaborative patient-family centered approach:
Above expected: (The team) elicits family and community information, and actively seeks to involve both in the patient's care plan. **At expected**: (The team) elicits some family or community information.
Below expected: (The team) fails to elicit any information about the patient's family or home setting.

Conflict management resolution:
Above expected: (The team) recognizes areas of potential conflict and elicits ways to resolve them; and agrees on a process to anticipate future conflict.
At expected: members listen to one another, ask for feedback if not clear and recognize conflict.
Below expected: members argue in front of the patient with no mechanism for resolving the arguments.

Team functioning:
Above expected: (The team) is able to reflect on its own actions and purpose and change dynamics to achieve excellence in team function.
At expected: demonstrates recognition of its function as a unit and discusses communication strategies.
Below expected: has no recognition of the need to function as a unit; individuals make decisions according to their own opinion.

Global rating score: Provide an overall rating for the team's performance based on all the factors above.

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EMMC Family Medicine Center and Residency Program
895 Union Street, Suite 12, Bangor, ME 04401
207-973-7979 Fax: 207-947-9579

Home Visit

Patient Name: _____ **DOB**: _____

Family Members: _____

Addresses and telephone numbers of family members: _____

_____

Impairments/Immobility

Activities of daily living (ADL):	Yes	No
Instrumental ADLs:	Yes	No
Balance and gait problems:	Yes	No
Sensory impairments:	Yes	No

Nutrition

Meals: _____

Variety and quality of foods:
- Pantry: _____
- Refrigerator: _____
- Freezer: _____

Nutritional status:
- Obesity: _____
- Malnutrition: _____
- Other: _____

Alcohol presence/use: Yes No

Home Environment

Neighborhood: _____
Entrance to home/fall risk (sidewalk, stairs, rugs): _____
Interior of home (safety issues): _____
Housekeeping: _____
Pets: _____
Books: _____
Television: _____
Memorabilia: _____
Proximity of grocery store/pharmacy: _____

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Other People

Social Supports: _____

Living Will: _____

Power of Attorney: _____

Financial Resources: _____

Medications

Prescription drugs: _____

Non-prescription drugs: _____

Dietary supplements: _____

Medicines organized: _____

Medication compliance: _____

Examination

Blood pressure: _____

Mini-Mental Status: _____

General physical condition: _____

Functional Assessment

Able to use phone, phone book, checkbook: _____

Assess gait, ability to get out of chair, use stove, sink: _____

Safety, Spiritual Health and Services

Bathroom: _____

Kitchen: _____

Carpets (esp. throw rugs): _____

Lighting: _____

Electrical Cords: _____

Stairs: _____

Tables, chairs and other furniture: _____

Fire and smoke detectors: _____

Fire extinguishers: _____

Emergency plans: _____

Access to Emergency Phone Numbers: _____

Evacuation route: _____

Gas or electric range: _____

Hot water heater < 120 degrees: _____

Heating and air-conditioning: _____

Water source: _____

Spiritual health: _____

Home health services: _____

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Eastern Maine Medical Center Patient Survey

Name: _____ Visit Date: _____

Please circle the number 1 through 5 that best describes how satisfied you were with the following:	Very Dissatisfied (1)	Moderately Dissatisfied (2)	Average Satisfaction (3)	Moderately Satisfied (4)	Very Satisfied (5)
1. How satisfied were you with your home visit?	1	2	3	4	5
2. Did you understand the reason for the home visit?	1	2	3	4	5
3. Did the providers express interest in your overall health?	1	2	3	4	5
4. Did the provider listen to you?	1	2	3	4	5
5. Did you feel comfortable and safe during your home visit?	1	2	3	4	5
6. Did the providers explain treatment options, medications, tests, or procedures?	1	2	3	4	5
7. Were you satisfied with the advice and treatment?	1	2	3	4	5
8. Do you understand your plan of care from today's visit?	1	2	3	4	5

What would have made this home visit more satisfying for you? Are there any suggestions for improvement?

Thank you for taking the time to fill out our patient survey!

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Interprofessional Education Frequently Asked Questions

Question: How will I know when I am scheduled to go on an IPE community-based home visit?

Answer: You will be given a schedule in your Family Medicine Orientation packet. Frank Bailey will email you the Monday before your visit with instructions. Heather Reid is the social worker that accompanies the students on Tuesday morning visits and on Thursday afternoon visits.

Question: When will I receive an email with the sample home visit form, IPE Self-Reflection Survey, and the IPE Initiative URL link?

Answer: This will be emailed to you on the Friday before the start of your FM rotation. This will give you adequate time to look over the information, review the video, and to ask any questions you may have before your visit.

Question: Who will contact me with patient information?

Answer: Heather Reid will contact pharmacy students and email Vicky Kennedy at FM the patient information. ****If the medical student is going out on Tuesday and has not received patient information by 1pm Monday, please email or call Amy Ludwig (contact sheet). If the medical student is going out on Thursday and has not received patient information by 1pm Wednesday, please email or call Amy Ludwig. Amy schedules the patients and can give you patient information and times.

Question: What do I need to bring on my visit?

Answer: The Home Visit Form (as a guide), Purell, and a change of clothes to have if needed. Medical students need to bring a blood pressure cuff and stethoscope.

Question: When does the Self-Reflection Survey need to emailed back?

Answer: The Self-Reflection Tool needs to be sent back the same day as the patient visit. If you go on Tuesday, the form is due back on Tuesday by 10pm and if you go on Thursday, the form is due back on Thursday by 10pm.

Question: What does the day of the visit look like?

Answer: Please review the URL link to get a feel for what the visit may look like. The community-based team meets for a half hour the morning of the visit to review patient information and travel together to the patient's homes. After each visit, the community team should debrief and discuss visit information, questions, and concerns.

Question: Who can I talk to after the visit about feedback (pt. notes, subjects covered, plan, etc.)?

Answer: The car ride home is a great time for the community team to discuss what occurred on the visit(s). When the students arrive back at the facility they can request time to meet with the patients' PCP to review notes and follow up plan. The IPE participants will meet with the community-based home visit team that week to discuss your experience during a debrief session. back to top

Question: I have not had any concerns for patient wellbeing in the two visits I have been to so far but if I did it would be great to have a formal channel or "go to" person to contact with the concerns that I had perhaps from things in the physical exam or obtained through the history/ROS. Perhaps these connections are already in place and I am just not aware of them?

Answer: This is a great question. The patient's physician is the best person to go to. Be proactive and seek out the physician and see if you can either have an impromptu conversation or set up a more formal meeting time. During this time you can ask your questions, state your concerns, and receive feedback on your course of action. The other person you can utilize while at FM is Dr. Pritham. He is the Lead Preceptor for FM and is a wonderful source of information.

Question: Do I fill out an IPE Self-Reflection Tool for each visit.

Answer: If visits occur consecutively on one day, only one Self-Reflection needs to be filled out and emailed in. If visits are done on separate days during the week, please fill out the form for each different day.

Question: After the recommendations have been made from the IPE team, is the patient being seen by the provider?

Answer: Dr. Pritham and/or the patient's PCP will review your home visit notes after they are entered into Centricity. You can discuss your plan of care with the provider and decide the best course of action to be taken.

Question: After the community-based home visit, what should I do with my Home Visit Form?

Answer: The Home Visit Form should be entered into Centricity upon return from the community visit. The form should be forwarded to the PCP and Dr. Pritham, either one can provide a signature. Please note that the Home Visit Form is given to you as a reference and not as a mandatory checklist on your home visit. Utilize accordingly.

Question: Should I contact anyone before the visit?

Answer: All students will be sent a calendar with the student they will be going out with on the visit (also access here). The students may exchange emails and phone numbers. The administrator going on the visit can be contacted, as well. Heather Reid and Amy Ludwig are your contacts.

Questions: Is there a portable BP cuff available to IPE students if needed? If there is, who can the medical student approach for this information?

Answer: Family Medicine has a kit for home visit that includes various size BP cuffs; this is available at the nursing station to sign out.

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Question: What patient information is most useful when preparing for the home visit?

Answer: A good guideline as what to focus on is the reason for recent ED visit(s) and preventing readmission and look at the previous discharge summary. A goal of the IPE Initiative is to reduce readmission rates through improving patient health, so a focus on the reason for admission will assist you in cluing into what should be addressed on the home visit.

Question: I have been through orientation, I have watched the promotional video, I even understand that I am meeting with the patient in their home, but what else do I need to know – I want to be prepared?

Answer: There is no set preparation to IPE – review the home visit form and the IPE self-reflection, but this is not a script. You are conducting a home visit, much like you would an office visit, so your roles and responsibilities should reflect just that; the rest depends on the home visit and like snowflakes, no two are alike. A side benefit is that the IPE program will assist in building improvisation, which you will employ as you increase your repertoire, along with a deeper understanding of underlying issues that each and every patient may be bringing into your office.

Question: Is the IPE debrief mandatory?

Answer: The IPE debrief is absolutely mandatory and this group session will need to be attended after each and every home visit. An e-mail will be sent to you by the IPE coordinator with the date, time, and location of your weekly IPE debrief. This is the culminating experience that requires face to face interaction to fully process the events of the CCT home visit. If you have questions or concerns regarding this, please contact the IPE coordinator at least 24 hours in advance, Frank Bailey, at 207-973-9060.

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Giving Constructive Feedback

By **Marty Brounstein** from **Coaching and Mentoring For Dummies**

Performance feedback can be given two ways: through constructive feedback or through praise and criticism. Don't fall into the trap of giving praise and criticism on performance.

- **Constructive feedback is information-specific, issue-focused, and based on observations.** It comes in two varieties:
  Praise and criticism are both personal judgments about a performance effort or outcome, with praise being a favorable judgment and criticism, an unfavorable judgment. Information given is general and vague, focused on the person, and based on opinions or feelings.
- **Be direct when delivering your message.** Get to the point and avoid beating around the bush. Both negative and positive feedback should be given in a straightforward manner.
- **Avoid "need to" phrases, which send implied messages that something that didn't go well.** For example, "Jane, you need to get your reports turned in on time, and you need to spell check them." This message is not really performance feedback. It implies that Jane did not do something well with her reports, but it doesn't report exactly what happened. Providing clarity on what occurred is the aim of feedback.
- **Be sincere and avoid giving mixed messages.** Sincerity says that you mean what you say with care and respect. Mixed messages are referred to as "yes, but" messages. For example, "John, you have worked hard on this project, but. . . ." What follows is something the person is not doing well and is the real point of the message. The word "but," along with its cousins "however" and "although," when said in the middle of a thought, create contradictions or mixed messages. In essence, putting "but" in the middle tells the other person, "Don't believe a thing I said before."
- **In positive feedback situations, express appreciation.** Appreciation alone is praise. Yet when you add it to the specifics of constructive feedback, your message carries an extra oomph of sincerity. For example: "Sue, your handling of all the processing work while John did the callbacks made for an efficient effort and showed good teamwork. Everything you did was accurate, as well. Thanks so much for helping out. Such initiative is a real value to the team."
- **In negative feedback situations, express concern.** A tone of concern communicates a sense of importance and care and provides the appropriate level of sincerity to the message. Tones such as anger, frustration, disappointment, and the ever-popular sarcasm tend to color the language of the message and turn attempts at negative feedback into criticism. The content of the message gets lost in the noise and harshness.
  The purpose of negative feedback is to create awareness that can lead to correction or improvement in performance. If you can't give negative feedback in a helpful manner, in the language and tone of concern, you defeat its purpose.
- **Give the feedback person-to-person, not through messengers of technology.** The nature of constructive feedback is verbal and informal. That can be done only by talking live to the employee, either face-to-face — or by phone when you physically can't be together.
- **State observations, not interpretations.** Observations are what you see occur; interpretations are your analysis or opinion of what you see occur. Tell what you've noticed, not what you think of it, and report the behavior you notice at a concrete level, instead of as a characterization of the behavior. Observations have a far more factual and nonjudgmental aspect than do interpretations.

Positive feedback is news or input about an effort well done.

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Negative feedback is news about an effort that needs improvement. Negative feedback doesn't mean a terrible performance, but rather a performance in which the outcomes delivered should be better. So negative is not a negative word in this case.

The guidelines for giving constructive feedback fall into four categories: content, manner, timing, and frequency.

Content

Content is what you say in the constructive feedback.

1. **In your first sentence, identify the topic or issue that the feedback will be about.**
2. **Provide the specifics of what occurred.**

Without the specifics, you only have praise or criticism. Start each key point with an "I" message, such as, "I have noticed," "I have observed," "I have seen," or when the need exists to pass on feedback from others, "I have had reported to me." "I" messages help you be issue-focused and get into the specifics.

Manner

Manner is how you say the constructive feedback. As you may know, how you say something often carries more weight than what you have to say — manner is an important element when giving feedback.

Timing

Timing answers this question: When do you give feedback for a performance effort worth acknowledging?

The answer is ASAP (as soon as possible). Feedback is meant to be given in real-time, as close as possible to when the performance incident occurs so that the events are fresh in everyone's minds. When feedback is given well after the fact, the value of the constructive feedback is lessened.

When giving negative feedback, you may want to apply a different timeline: ASAR (as soon as reasonable/ready — that is, when *you're* ready). Sometimes when an incident happens, you aren't feeling too good about it, and you need time to cool off and get your thoughts in order before you give negative feedback (so that your manner displays a tone of concern). Doing that may mean giving the feedback tomorrow rather than right now, but tomorrow is still timely, and your feedback will come across as far more constructive.

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HOW TO PRINT A CLINICAL CHART SUMMARY IN CENTRICITY

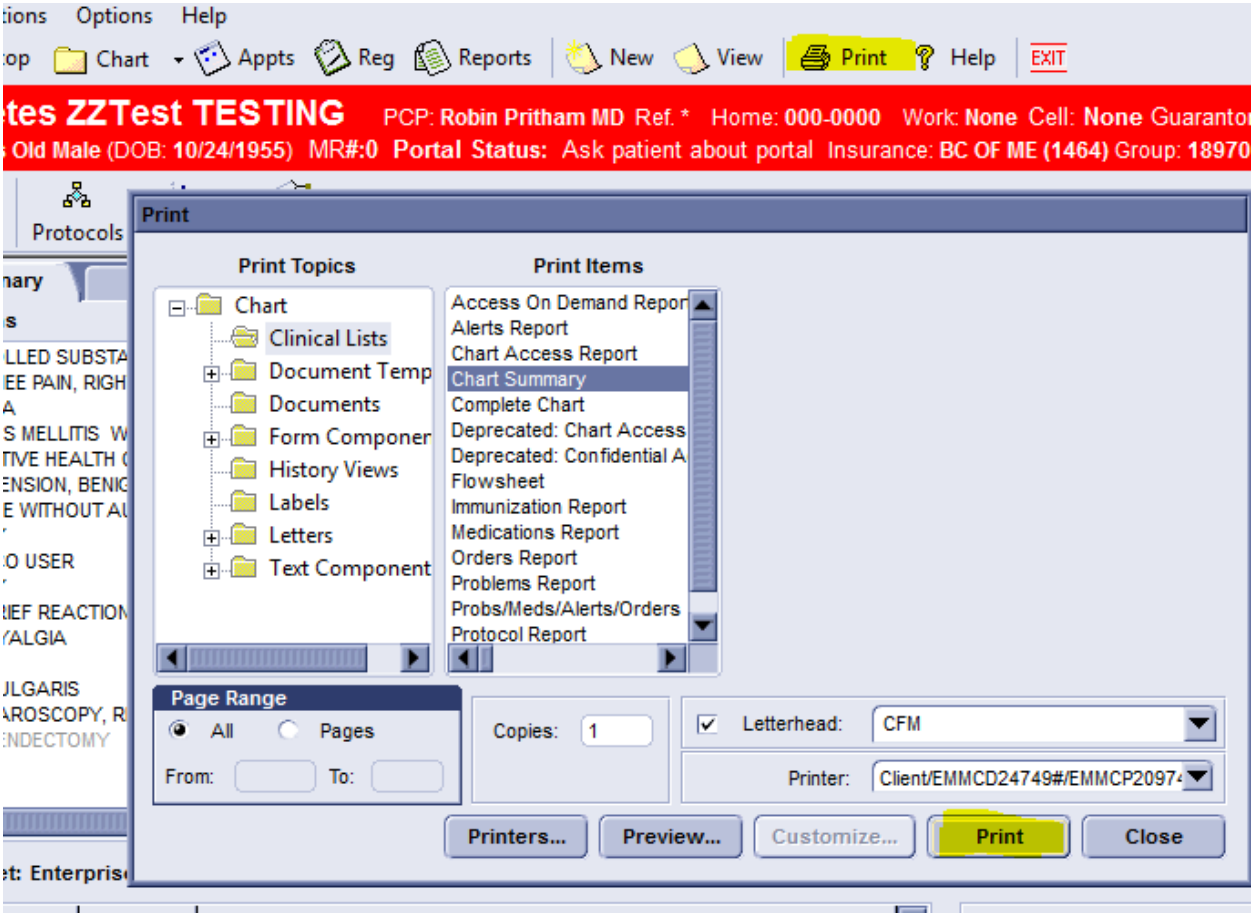
This document will provide demographic information, problem list, medication list and allergies. This is a great form to take along for an IPE Home Visit and to make notes on.

In the patient's chart select the **print icon** (center area above the patient banner)

Select the **Clinical Lists folder** from the Print Topics

Select the **Chart Summary** from the Print Items

Print out the list



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HOW TO START A **CFM HOME VISIT** IN CENTRICITY

This document will provide prompts for many of the items that are evaluated at a home visit.

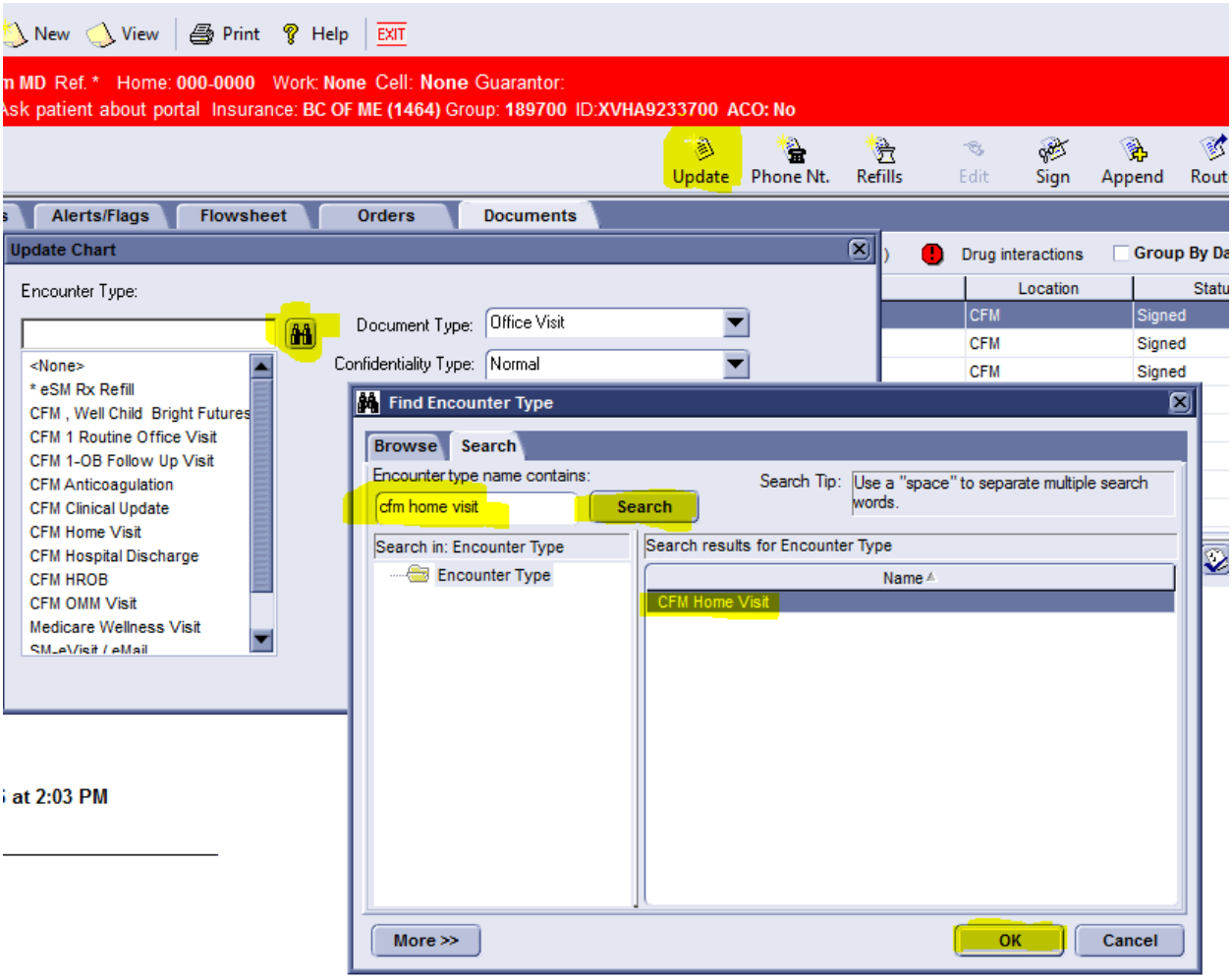
You can free text a SOAP note for the "medical content" of the visit also.

Click on the **UPDATE** icon located below the patient banner towards the right.

At the **UPDATE CHART** window select the binoculars to open up FIND ENCOUNTER TYPE

Type **CFM HOME VISIT** in the search window and make sure CFM Home Visit is selected.

Click on **OK** and your document will open up.



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