Teaching While Learning While Practicing: Reframing Faculty Development for the Patient-Centered Medical Home

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Abstract

Soaring costs of health care, patients living longer with chronic illnesses, and continued attrition of interest in primary care contribute to the urgency of developing an improved model of health care delivery. Out of this need, the concept of the patient-centered medical home (PCMH) has developed. Amidst implementation in academic settings, clinical teachers face complex challenges not previously encountered: teaching while simultaneously learning about the PCMH model, redesigning clinical delivery systems while simultaneously delivering care within them, and working more closely in expanded interprofessional teams.

To address these challenges, the authors reviewed three existing faculty development models and recommended four important adaptations for preparing clinical teachers for their roles as system change agents and facilitators of learning in these new settings. First, many faculty find themselves in the awkward position of teaching concepts they have yet to master themselves. Professional development programs must recognize that, at least initially, health professions learners and faculty will be learning system redesign content and skills together while practicing in the evolving workplace. Second, all care delivery team members influence learning in the workplace. Thus, the definition of faculty must expand to include nurses, pharmacists, social workers, medical assistants, patients, and others. These team members will need to accept their roles as educators. Third, learning to deliver health care in teams will require support of both interprofessional collaboration and intraprofessional identity development. Fourth, learning to manage change and uncertainty should be part of the core content of any faculty development program within the PCMH.

Soaring costs of health care, patients living longer with chronic illnesses, and continued attrition of interest in primary care contribute to the urgency of developing an improved model of health care delivery. Out of this need, the concept of the patient-centered medical home (PCMH) has developed. The PCMH model of care is expected to be team based, emphasize prevention of illness, and provide enhanced access to better-coordinated, more efficient, higher-quality chronic care.1–6

Health professions faculty charged with preparing learners for their futures in PCMH settings face several challenges.7–10 To simultaneously deliver care and redesign systems of care, PCMH content, knowledge, and skills must be learned. As practice transformation is already taking place, the tradition of learning first and teaching second is lost. Uncertainty about best practices for implementing the PCMH model’s key elements in academic teaching practices means the blueprint is also missing. A new model for faculty development is needed that supports teaching while learning while practicing and continually improving. Because training sites’ adoptions of PCMH principles are not uniform, this new faculty development model must be relevant whether the teaching practice is already certified as such by the National Committee for Quality Assurance, is in transition to a PCMH, or is just contemplating implementation.1,4,6

In this article, we consider three existing faculty development models6,11,12 that identify important elements supporting the professional development of clinical teachers responsible for preparing learners for their futures in a PCMH. Building on these models, we identify four adaptations necessary to support simultaneous practice transformation and educational reform. This work originated from discussions at the Society of General Internal Medicine’s (SGIM’s) PCMH Education Summit in 2011. This summit brought together leaders—from medical disciplines in university- and community-based internal medicine, family medicine, and pediatrics, and from nursing, pharmacy, and several national internal medicine organizations—to identify the educational implications of practice transformation to PCMH models. At the summit, workgroups systematically discussed domains of education relevant to the PCMH. The summit process is described elsewhere.13 Using an iterative process, we, as members of one of the workgroups, developed the recommendations that we present later in this article, based on a review of the faculty development literature, discussions that took place at the summit, and the recommendations of the other workgroups from the summit. For the purpose of this report, we use the term learner to include any student or trainee engaged at any level of health education in professions germane to PCMH models.
Foundations for Faculty Development

The classic, linear model of faculty development that began in the 1950s assumes that one’s participation in faculty development, typically delivered through workshops, leads to changes in one’s teaching behaviors and effectiveness, which in turn improve the actions of learners who will subsequently deliver better patient care as a result.6,14 Although active learning methods are frequently used, developing teaching skills in the workshop setting is decontextualized from actual practice. In a systematic review of faculty development, Steinert and colleagues9 noted workshops to be the most common type of intervention, with few authors describing a direct link between the intervention and the teachers’ subsequent ongoing educational practices.

In contrast to this workshop approach, O’Sullivan and Irby11 propose a workplace faculty development model based on current theories that recommend for learning to take place in context. Thus, learning how to teach should take place where teaching actually occurs, in the clinical practice. Although the purpose of O’Sullivan and Irby’s11 review of research on faculty development was to redirect research about what works in faculty development, we consider their model a useful starting place for designing professional development programs to prepare faculty for their teaching roles in the academic PCMH, where health professions learners are clinically trained. The O’Sullivan and Irby11 model for professional development describes two interacting communities of practice. For the purpose of this article, these two communities are (1) faculty seeking support for their teaching roles and responsibilities, and (2) health professionals delivering clinical care in the academic PCMH practice. Faculty, the primary target of professional development, belong to both communities.

A third model, proposed by Silver and Leslie,12 also situates faculty development in the workplace. This model focuses on interprofessional education (IPE) and collaborative practice development for the community of health professionals working and learning together to improve team-based care delivery. Silver and Leslie’s12 model, which addresses several important dimensions, states that health professional faculty should develop attitudes, knowledge, and skills for collaborative practice; enhance teamwork; support evidence-based practice; address quality improvement and patient safety; develop leadership skills for managing organizational change; and enhance teaching and learning. Their model ensures from the beginning that the faculty development process simultaneously involves interprofessional learning, clinical practice enhancements, and quality improvement. This approach enhances collaboration and is grounded on team members’ positive attitudes toward individuals from different professions. On the basis of current understanding of role modeling as an instructional practice, Silver and Leslie12 argue that faculty development activities themselves should be designed in ways that model effective IPE methods and practice in the workplace. Although highly relevant for teaching in the team-based PCMH learning environment, Silver and Leslie’s12 focus on the practice team as the target audience is distinctly different from that of the other models, which focus on the clinical teacher. Only one of the six components of their model, teaching and learning, addresses the roles and responsibilities of these team members to engage with health professions learners and facilitate learning in the workplace. However, by focusing on the existing practice team, this model emphasizes improving all aspects of the environment where learning takes place.

Reframing Faculty Development for the PCMH

The faculty development models of O’Sullivan and Irby11 and of Silver and Leslie12 highlight three important considerations for preparing clinical teachers for their roles as educators in a PCMH. First, faculty development activities should focus on learning and applying new skills in the workplace. Second, to achieve this goal, two communities of practice must be supported: the clinical practice team in the workplace, where teaching and patient care take place, and the community of faculty with core responsibilities for educating.11 And, third, because the PCMH is team-based care by definition, interprofessional education must be the focus of faculty development efforts.12

Although these core elements are likely necessary for successful faculty development, we believe they are insufficient for full preparation for teaching within the PCMH. We propose below four adaptations to these models that further address the unique challenges of supporting health professions faculty in PCMH settings. We wish to emphasize that our adaptations are additive to the important dimensions that Silver and Leslie12 and others describe, such as leadership development, team building, and organizational change management. Indeed, by engaging faculty and leaders at multiple levels in the organization, faculty development activities have agency in organizational culture change.12

Adaptation 1: Learn together while practicing in the workplace

The classic linear faculty development models assume a two-step process: Clinical teachers will first learn new content and then teach it. However, because practice transformation is already under way, the luxury of learning first and then teaching must be abandoned. Not many faculty in health care training programs have expertise in PCMH content areas such as interprofessional teamwork, continuous quality improvement, and population-based care.15,16

Models of teaching while learning and practicing, however, do exist. For example, implementation of electronic health records (EHRs) in academic settings required faculty and learners to retrain together. In fact, given younger learners’ comfort and relative skills with technology, they may acquire expertise at faster rates than some faculty. Those seeking faculty development in preparation for teaching and implementation of PCMH principles may learn from these and other examples of teaching while learning. PCMH implementation and new curricula, however, will often combine multiple concurrent complex teaching-while-learning themes, including effective implementation and use of EHRs, population management, practice change, and interprofessional teamwork, among others. Faculty may find themselves at the uncomfortable place of being expected to teach before they can master such.
new content. Thus, “learning together while practicing” becomes an important adaptation for faculty development in the academic PCMH. Until the PCMH model matures and best practices are established, learners and faculty will face similar learning challenges, and the hierarchical model of “expert teaches learner” in these new content areas will not exist.

We provide three ideas for implementing this adaptation.

First, include learners alongside faculty in clinical team discussions and planning meetings. These discussions and meetings are part of the workplace where learning occurs and where learners’ presence serves as a reminder that the teaching mission is integral to improving delivery of patient-centered care. Learners may not be on-site because of other learning or clinical obligations (lectures, in-patient rotations, seeing patients at other clinics), but the use of technology, such as videoconferencing, Skype, or conference calls, should facilitate learners’ involvement.

Second, invite learners to become more expert on relevant PCMH topics and assist with teaching those topics to others.

Third, because PCMH topics of discussion require multiple perspectives, implement a new model for the “teaching conference” that expands participation to include faculty, learners, and clinical practice staff. Engaging faculty and learners in team-based interprofessional quality improvement would be another method to teach, learn, and practice together.17,18

Adaptation 2: Expand the definition of faculty

In graduate medical education, we traditionally think of “faculty” as the physician educators who hold academic positions at teaching institutions, and distinguish them from the “staff” who facilitate clinical care delivery, or from “patients” from whom learners learn.19 As workplace transformation to PCMH models occurs simultaneously with educational redesign, all team members—physicians, nurses, medical assistants, social workers, pharmacists, receptionists, practice managers, and even patients themselves—are engaged in learning and teaching new ways of delivering patient-centered care and should be considered “faculty” in the medical home context for the purposes of facilitating the redesign of practice and education. This nontraditional designation would foster the sense that anyone on the team can contribute to the team’s education and is to be targeted for faculty development. As central team members, patients should be advised of their teaching role within the practice and invited to contribute to the educational mission.20 For example, patients can be invited to share their experiences of living with chronic illnesses, thereby bringing the patient’s voice to the ongoing important conversation.

Importantly, these new faculty must accept their roles as faculty and engage in changing their identities from health care worker alone to team member and teacher. Similarly, traditional faculty, who could feel threatened by their loss of perceived authority, should support and embrace these new faculty members. The new faculty must be included in faculty development activities. Further, we believe that learners must recognize these team members as faculty who have important roles in learners’ education.

We provide two ideas for implementing this adaptation.

First, formalize orientation of learners to the PCMH practice setting, including introductions of all team members to each other and a discussion of roles and responsibilities in the learning environment. Emphasize that all team members have responsibilities for facilitating the learning of others, and thus are faculty.

Second, implement an assessment process that elicits and values input from all team members about each other’s performances in the PCMH setting. This will require a psychologically safe environment for honest, nonjudgmental discussions.21 We believe interprofessional assessment has the potential to encourage learners to view other team members as legitimate teachers.

Adaptation 3: Support interprofessional and intraprofessional development

How might an interprofessional faculty development community differ from a traditional community of faculty from a single profession or discipline? For many physicians and other health care professionals, participating in professional development that transcends traditional discipline boundaries will be a new experience. The unique teaching and practice cultures of the different professions will need to be deliberately explored. Common languages with shared meaning will need to be developed. Traditional hierarchies will need to be dissolved. As Silver and Leslie recommend, team members “can benefit from articulating their common competencies, their complementary competencies that distinguish one profession from another, and their collaborative competencies” necessary for effective teamwork.

Although a fully integrated interprofessional faculty development workplace community will be necessary for modeling collaborative practice, retaining time to spend with one’s own professional peers reflecting on and interpreting change in the context of one’s primary professional identity will still serve an important function. Support for such parallel interprofessional and intraprofessional communities of practice will likely be complementary and beneficial for faculty development in a PCMH.

We provide two ideas for implementing this adaptation.

First, form a community of practice with all members of the clinical practice team and meet regularly to discuss the educational mission, reflect together on teaching actions, and reinforce the teaching roles for each member.

Second, determine and address professional development needs for members of this community of practice. Start with learning more about each other’s professional values and contributions to delivering patient-centered care. Seek (or develop) opportunities for shared professional development. Ideally, a dispassionate facilitator without ties to a particular profession would start these conversations.

Adaptation 4: Managing change and uncertainty

The PCMH is an evolving concept and must be tailored to each local context over time. It follows that faculty development within this model must also continually evolve. Adaptability,
therefore, becomes an overarching skill to be taught and learned.25,26 Yet, deliberately considering uncertainty and change management as part of the faculty development curriculum is only occasionally found in current health professions training programs.9

Change is difficult for most faculty and is especially challenging in the face of uncertainty. To succeed in the face of uncertainty, strategies that include reflective practices should be a deliberate part of preparing faculty for their roles as teachers in a PCMH.25 For example, although presently unproven in this setting, change management training founded on the principles of appreciative inquiry (AI)26 and asset-based thinking27 although presently unproven in this setting, change management training founded on the principles of appreciative inquiry (AI)26 and asset-based thinking27 models may enhance the sense of control that individuals feel over their response to their environment. Those who use AI techniques focus on successes rather than approaching life from a predominantly problem-based perspective. Emphasizing a positive focus on assets helps individuals to build from their strengths, generating a sense of empowerment and influence to drive the innovation that is necessary for redesigning health care and education.28,29

We suggest that this adaptation be implemented through reflection on workplace activities and actions. These reflective activities should take place in both communities. Reflection in the workplace community will focus on what works well to achieve best outcomes in team functioning and patient care. Reflection in the faculty development community will focus on what the team is doing well to manage change and uncertainty. As these are early proposals, they will require testing to build evidence of their efficacy in the PCMH setting.

Summary of Proposed Adaptations

As PCMH models of care delivery are implemented in academic settings, faculty face complex challenges. They must teach about concepts they have yet to master themselves. They must redesign delivery systems while delivering care within them. They must build new team-based relationships with other health professionals. They must support learners’ development of these skills in order to prepare them for their future practice in PCMH settings. Building from three faculty development models, we recommend four important adaptations for preparing faculty for their roles as facilitators of learning in these new settings.

• First, accelerated practice transformation requires faculty and learners to learn together while practicing in the workplace, abandoning the tradition of learn first then teach.

• Second, because all members of the clinical team will influence learning in the workplace, faculty must be broadly defined to include the entire clinical team, including patients.

• Third, interprofessional team-based care models require new appreciation for what other professions bring to the teaching mission. New faculty development models should support both interprofessional collaboration and intraprofessional reflection on learning to collaborate.

• Fourth, managing change and uncertainty using positive, asset-based approaches to develop faculty’s adaptability skills must be a core component of any faculty development program.

Adapting existing faculty development approaches to include these recommendations may best be accomplished as a shared activity across academic practices through networking and sharing resources and expertise. As is evident from the SGIM PCMH Education Summit, national organizations can help create and support this faculty development network to accelerate learning about best practices that support simultaneous transformation of clinical practice environments and educational programs focused on preparing the primary care workforce of the future.

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References


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