Lessons learned from implementing EBPs into community based primary care medicine

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Background

- 15 years training experience in safety net clinics;
- EBPs and collaborative/integrated care;
- Nurses, social workers, psychologists, Mas;
- Alameda, Contra Costa, Los Angeles, Marin, San Francisco, Santa Clara counties; NHS Scotland as well.
- I've just about seen/heard it all…

Challenges

- Every county and clinic is different.
- Moving existing staff to new setting with out preparation;
- No clear model for helping staff adjust;
- Most staff not educated in brief models;
- Re-training takes far too long;
- No clear incentive (other than keeping the job);
- Velvet glove versus iron fist management.
- We need training programs for existing staff and new clinicians.

Skills needed by clinicians

- Experience/exposure to working in primary care;
- Measurement based decision making skills (panel management);
- Collaborative;
- Assertive (don't be afraid of the doctor);
- Efficient with time/good time management skills;
- Brief treatment;
- Willingness to let go of cases, move them on to specialty care;
- Willingness to check in with medications.

Method for developing those skills

- Scaffolding:
  - Introduce them to primary care culture – shadow a doc for one week;
  - Start with simple management approaches;
  - Use of case-based training.
- Consultation:
  - Review of cases with team;
  - Reinforce the integrated care model by working with the team initially, until it runs itself;
- Start early!
  - Programs in graduate school focused on integrated care;
  - Internships that focus only on integrated care.

Not just the clinician…

- “transformative” leadership to inspire change (Aarons, et al, 2012);
- Better workplace training – allow time to learn;
- Better access to experts (and experts need to be in the clinic);
- Involve HR to develop assessments, work goals, and incentives.
- Work with HR to help them hire the “right” person, or identify clinicians willing to change their practice.

Moving forward

- Clear on-the-job training;
- Access to consultants to help the transition;
- Graduate (or undergraduate) programs focused specifically on a “new breed” of clinician who can work in PCM;
- Better HR directives to sustain practices.