

Outcome-Based Healthcare and Interprofessional Practice

James Kundart

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From the Editor

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It's high political season in America. Since the last issue of HIP, we have nominated two candidates who are currently sparring for the privilege of being the next U.S. president, and our Supreme Court has upheld the constitutionality of the Affordable Health Care law. Like the enactment of Social Security in 1935 and Medicare and Medicaid in 1965, this healthcare reform is engendering as much debate as those major social reforms that preceded it.

While the future of the Affordable Health Care law is dependent in part on the outcome of the presidential election, one of the issues orbiting the law involves provider reimbursement. In order for any of us to continue to afford America's excellent quality, but increasingly expensive, healthcare, it may be required that we demonstrate that our patients are actually getting better. We are already seeing low-cost preventative medicine become standard in optometry, in the form of routine blood pressure and body mass index taken on every patient we see. Outcome-based care is affordable care.

On the topic of outcome-based healthcare, there are two contributions to original theory and research in this issue of HIP. Hartrick Doane et al. discuss the role of interprofessional care in patients at the end of life. In this action research study, the authors explore four "rational disjunctures" within the interaction of multiple professions that interfere with the quality of palliative care. Addressing these disjunctures will hopefully lead to greater effectiveness and efficiency—in short, better outcomes for this population.

Pharmacology presents another major interprofessional juncture and opportunity for improved outcomes. Increasingly, it is apparent that all healthcare professionals

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need to be vigilant to monitor drug interactions beyond each provider's specialty. As a case-in-point, Hua et al. studies the effects of pilocarpine on ocular and oral function, and how that affects optometric and dental care. In the case of this generic and generally recognized as safe drug, tear production in the eyes and salivary function in the mouth are both increased, affecting the health of both the eyes and the teeth, often for the better.

Patient care is not the only area in healthcare in which outcomes are important. In the first of two major educational strategy pieces in this issue, Bridges & Hanson discuss "Mapping and Integrating Online Interprofessional Teaching Strategies to Achieve Interprofessional Student Competencies." Using the examples of Health Administration and Health Professions Education, this contribution discusses how outcome-based assessment can be used in distance education—yet another tier of our multifaceted healthcare system.

Our other educational strategy paper is "A Coordinated Care Clinical Education Practice Model to Promote Health," in which Timpone discusses the experience of developing, operating, and evaluating an interprofessional diabetes clinic. In this clinic, students and fac-

ulty in occupational and physical therapy, optometry, pharmacy, physician assistant studies, and professional psychology see the same patients on the same day. The patients seen in this monthly clinic are mostly Latino, and as the author says, the clinic coordinates “follow-up care, referrals, patient/family health and lifestyle education, and preventive services delivered by the healthcare team and community.” This interprofessional clinic model works to ensure that both outcome-based education and care are achieved.

Also related to diabetes is the examination of a fictitious, but representative, case presented at the *Integrative Medicine for the Underserved* conference. In a slightly unusual format for case-based learning, Clare recounts and comments on the interprofessional approach to tackle this case in an extremely low income patient population. Note that unlike other case-based learning pieces we publish, this one is not peer-reviewed, but I hope you find its creative approaches to patient care to be instructive.

Finally, we offer two commentaries on issues relevant to both patient care and provider education. The first is by Farinde, who discusses the need for pharmacist input on the prescription of psychotropic medications. The sticky issue is, as the author puts it, “Primary care physicians have been identified as prescribing a large majority of psychotropic medications to children and adolescents. Most cases are out of their scope of practice.” Yet the demands of managed care require greater levels of cooperation to provide an adequate level of mental health care at an affordable cost.

In something of a departure from our usual short commentaries, Vitale examines how the vocation of practicing medicine became reframed as an academic discipline, and why that shouldn't always be seen as a good thing. The craft of medicine may not be well served by requiring a didactic, knowledge-based education as a barrier to entry. While rarely questioned, there is proof that healthcare might benefit from divorcing itself from the Academy. The popularity of that approach can be found in high-demand, hands-on physician programs, such as the one at McMaster University in Hamilton, Ontario.

Whether explicitly or implicitly, the common theme from all of this issue's authors is this: outcomes matter. Outcome-based healthcare is evidence-based health-

care, and it is our hope that both will be improved by the contents that follow.

Welcome back to HIP!

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