Toward a System Where Workforce Planning, Education and Practice are Designed around Patients, Populations and Communities, Not Professions

Blending the Blues: A Collaboration with IPE4UNC and Duke AHEAD
February 21, 2018

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and

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The Official Disclaimer

- Fraher's work is supported by University Research Council Grant (UNC-CH) and National Center for Health Workforce Analysis (NCHWA), Health Resources and Services Administration (HRSA) under cooperative agreement #U81HP26495

- Brandt's work is supported by the Health Resources and Services Administration (HRSA) under Cooperative Agreement UE5HP25067, Josiah Macy Jr Foundation, Robert Wood Johnson Foundation, Gordon and Betty Moore Foundation, and the John A. Hartford Foundation

- The content, conclusions and opinions expressed in this presentation are the authors and should not be construed as the official policy, position or endorsement of their funders, their employers or the federal government.

The Unofficial Disclaimer

- Although Fraher has been staff, student and faculty at Carolina, she blends the blues regularly at home
- Husband, John Klingensmith, is Associate Dean for Academic Affairs at Duke's grad school
- Daughter, Anna Klingensmith, is a freshman at Duke and has always been a Cameron Crazie

…And as we are about halfway between the next Duke vs Carolina game, the timing of this meeting is perfect

February 8

BLENDING THE BLUES

A Collaboration with IPE4UNC and Duke AHEAD

Redesigning Health Workforce Planning, Education and Practice around Patients and Populations, not Professions

March 3

February 8
Duke @ Carolina

February 21
Blending of the Blues:

March 3
Carolina@ Duke

Brandt – Strong NC Ties
Protect identity of daughter –
We start advocacy young in our family

Valerie X – Social Worker

How we ended up giving this presentation together

- Found ourselves at odds with our professional communities
- Three years ago began to talk monthly and share learning
- Discovered common belief that more of same in health professions education and practice will have significant, negative consequences on population health and costs. . . and for our health professional graduates
- Now hitting the road to highlight that workforce planners and IPE educators need to work together to tackle education and practice redesign

This presentation in one slide

- Our collaboration grew out of frustration with our respective fields and a desire to forge a new, joint vision for future
- New Zealand is mental model for redesigning workforce, practice, and education around the patient, not professions
- You may think NZ's model is not applicable but cost, quality, technology, and focus on "consumer" pressures are driving similar reforms in the US, with or without the ACA (or a replacement)
- This shift will require moving from "old school" to "new school" approaches in workforce planning and IPE
- We believe the way forward for our fields is together

Current workforce planning approaches not fit for purpose to meet future challenges

Traditionally, workforce planning in the United States:

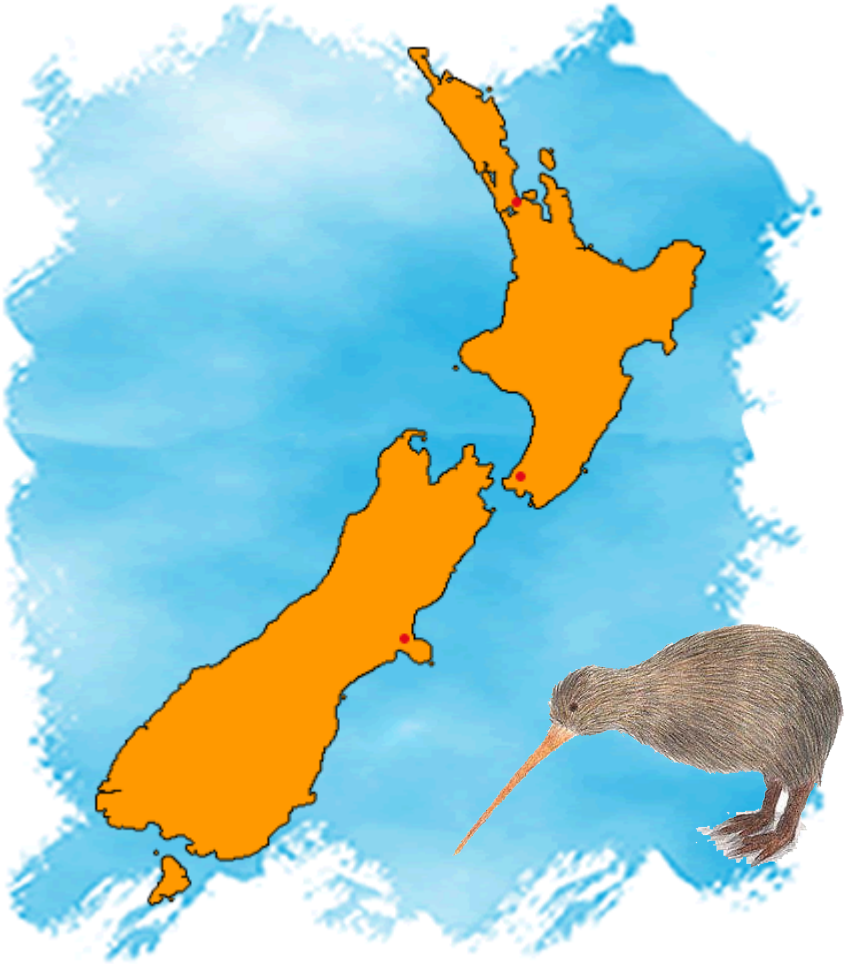
- Starts from professional, not population or health service perspective
- Focuses on “counting noses” by profession and specialty
- Includes limited definition of health workforce
- Is used to feed stakeholder agenda of “we need more”
- Is ***not*** used to redesign workforce, work flows and care delivery models to better meet patient needs

Field of IPE faces its own challenges

- For fifty years, IPE has lived on the margin: Perception that IPE's long history has led to limited change
  - Students are not going to change the health care system because of IPE and enthusiasm.
- You can't evaluate what you haven't done:
  - Limited (but growing!) evidence that IPE has led to improved patient outcomes and/or lower costs. Or, even makes a difference in learning beyond attitudes.

Interprofessional Education and Collaborative Practice: Welcome to the Acceleration of the "New" Fifty Year Old Field

Tired of swimming upstream, Fraher asked, “What Would the Kiwis Do?”



Health workforce challenges in New Zealand (sound familiar?)

- Current health workforce:
  - not sustainable
  - less productive than in past
  - too many workers not practicing anywhere near top of scope of practice
  - not meeting quality outcomes
  - poorly distributed against need
  - large proportion of workforce nearing retirement
- Primary care, mental health, oral health, and rehabilitation systems “not up to scratch”

New Zealand's approach: The Workforce Service Forecast (WSF)

- NZ asks "**What are patient's needs for care and how might health professional roles, regulation, education and practice be redesigned to meet those needs?**"
- Goal of WSFs: envision workforce needed to meet doubling of demand, with 15% increase in funding, maintaining (or improving) patient satisfaction
- Approach encourages outside-the-box thinking about what care pathways and workforce *should be*
- Instead of retrofitting care delivery models to meet the competencies and roles of the existing workforce

Health Workforce New Zealand's Workforce Service Forecasts

Health service areas

- Aged Care
- Anesthesia workforce
- Dermatology
- Diabetes
- Eye health
- Gastroenterology
- Mental health
- Musculoskeletal
- Palliative care
- Plastic surgery
- Rehabilitation

Populations

- Youth health
- Maori health
- Pacific health
- Mothers, fathers and babies

NZ's Workforce Service Forecasts: Process

- Transforms workforce and service delivery from ground up, rather than top down
- Designs "ideal patient pathways" by service area and identifies education, regulatory and practice changes needed to support new models of care
- Makes it personal: "How should we care for Aunt Susie with dementia?"
- Engages "coalitions of the willing" to overcome professional resistance and "tribalism"

NZ's Workforce Service Forecasts: Findings

Common WSF themes included need to:

1. increase supply of health professionals with generalist skills
2. diffuse expertise from acute to outpatient/community-based settings, particularly for mental health, rehabilitation, and geriatrics
3. modify education and regulation to allow task shifting between health professionals and expanded roles for the existing workforce, such as allowing advanced trained nurses to perform endoscopies

NZ's Workforce Service Forecasts: Findings (continued)

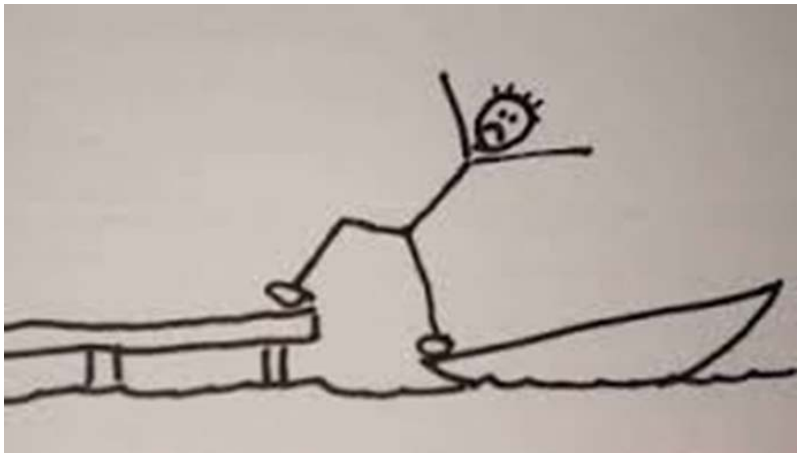
Common WSF themes included need to:

4. better integrate health and community-based workforce to address social determinants of health
5. address training needs of unlicensed health professionals
6. develop care coordination competencies across the workforce
7. incorporate technology into workflows

Sound familiar?

Meanwhile here in the US…. there's lots of uncertainty

- Most health care systems currently operating in predominantly fee-for-service model, but actively planning for value-based payment



- Medicare's payment incentives through MACRA will likely accelerate shift from volume to value-based and alternative payment models

Health care: Let 1,000 flowers bloom
Add IPE/HPE: Let 50,000 flowers bloom

- Hospitals and health systems are striving to achieve quadruple aim
- Ongoing experimentation underway to transform the way health care is paid for, organized, and delivered
- Less attention being paid to aligning workforce and education system to meet needs of evolving system
- Lack of attention to workforce may be reason that new care delivery and payment models are not showing expected outcomes*

*McWilliams JM. (2016). Savings from ACOs-building on early success. *Annals of Internal Medicine, 165*(12), 873-875.
Sinaiko AD, Landrum MB, Meyers DJ, Alidina S, Maeng DD, Friedberg MW, Rosenthal MB. (2017). Synthesis of research on patient-centered medical homes brings systematic differences into relief. *Health Affairs (Millwood),* 36(3), 500-508.

Parable of the boiling frog

- Health care is jumping out of the hot water to avoid dying, driven by multiple factors.
- Higher education/health professions education is slowly boiling as the heat is being turned up. We need a wake-up call and different conversations at the policy, systems, and classroom/clinical/ community levels.

How do we get there from here?

As the health system grapples with rapid change and significant uncertainty, need to shift focus from “old school” to “new school” workforce planning approaches

This section draws on work in press by E. Fraher and B. Brandt, “Toward a System Where Workforce Planning, Education and Practice are Designed Around Populations, Not Professions”

Reframe #1: From a focus on shortages to addressing the demand-capacity mismatch

Old School

- Will we have enough (nurses, doctors, *insert other health professional*) in the future?

New School

- How can we more effectively and efficiently deploy the workforce already employed in the health care system on interprofessional teams?

Shortage, No Shortage?
A shortage of workers, skills or training?

- **A shortage of workers?** Prevailing narrative focuses on shortages, but many (not all!) shortages could be addressed by reallocating tasks among providers
- **A shortage of teams?** Need to empower teams of licensed and unlicensed providers to reallocate work flows and redesign care pathways
- **A shortage of needed skills?** Workers with the right skills and training are integral to the ability of new models of care to constrain costs and improve care (Bodenheimer and Berry-Millett, 2009)
- **A shortage of training?** Lots of enthusiasm for new models of care but limited understanding of implications for education

Source: Bodenheimer TS, Smith MD. Primary care: proposed solutions to the physician shortage without training more physicians. *Health Affairs (Project Hope)*. 2013 Nov;32(11):1881–6.

Reframe #2: From a focus on provider type to recognizing plasticity of provider roles

Old School

- Assumes professions and specialties have fixed and unique scopes of practice

New School

- Recognizes “plasticity” of real world practice—professions and specialties have overlapping and dynamic scopes of practice

Workforce is highly flexible. We need to encourage practicing to fullest scope

- Plasticity recognizes that roles will dynamically change depending on patients' need for services, the setting and the availability of other providers
- Instead of retrofitting care models to meet existing competencies of the existing workforce, need to ask:
  - what are patients' needs for services?
  - how might health professional roles be redesigned to meet those needs?

This is already happening…..

Many, many new care coordination roles emerging

Emerging Roles

- Patient navigators
- Case managers
- Care coordinators
- Community health workers
- Community paramedics
- Care transition specialists
- Living skills specialists
- Patient family activator
- Peer and family mentors
- Peer counselors

Implications

- Many play role in patient transitions between home, community, ambulatory and acute care health settings
- Evidence shows improved care transitions reduce unnecessary hospital admissions, lower costs and improve patient satisfaction

Boundary spanning roles also growing quickly

"Boundary spanning" roles reflect shift from visit-based to population-based strategies

Two examples:

Panel Managers	Health Coaches
Assume responsibility for patients between visits. Use EHRs and patient registries to identify and contact patients with unmet care needs. Often medical assistants but can be nurses or other staff	Improve patient knowledge about disease or medication and promote healthy behaviors. May be medical assistants, nurses, health educators, social workers, community health workers, pharmacists or other staff

Reframe #3: From a focus on workforce planning for professions to workforce planning for patients/people, families and communities

Old School

- Silo-based workforce planning for individual professions

New School

- Workforce planning for services, patients, families and communities

Health workforce planning or planning a workforce for health?

Upstream, population health approach requires us to:

- Expand workforce planning efforts to include workers in broad range of health care, community and home-based settings

- Embrace the role of social workers, patient navigators, community health workers, home health workers, community paramedics, dieticians and other community-based workers

Social workers play increasingly important boundary spanning roles

We conducted a systematic review of randomized control trials (RCTs) and found that social workers are serving three roles on integrated behavioral health/physical health teams:

- Behavioral health specialists: provide interventions for patients with mental health, substance abuse and other behavioral health disorders
- Care Managers: coordinate care of patients with chronic conditions, monitor care plans, assess treatment progress and consult with primary care physicians
- Referral role: connect patients to community resources including housing, transportation, food, etc.

Fraser M, Lombardi B, Wu S, Zerden L, Richman E, Fraher E. Social Work in Integrated Primary Care: A Systematic Review. Program on Health Workforce Research and Policy, Cecil G. Sheps Center for Health Services Research. September 2016. http://www.shepscenter.unc.edu/wp-content/uploads/2016/12/PolicyBrief_Fraser_y3_final.pdf

New health care teams are emerging: Community Aging in Place—Advancing Better Living for Elders (CAPABLE) Teams

- An occupational therapist, a registered nurse, and a handyman form team allowing seniors to age in homes
- Provide assistive devices and make home modifications to enable participants to navigate their homes more easily and safely
- After completing five-month program, 75 percent of participants (n=281 adults age 65+) had improved their performance of ADLs
- Symptoms of depression and ability to perform instrumental ADLs such as shopping and managing medications also improved
- CAPABLE is now in 12 cities in 5 states with a mix of payers, including Medicaid waiver in Michigan

Source: Szanton SL, Leff B, Wolff JL, Robers K, Gitlin LN. (2016). Home-Based Care Program Reduces Disability And Promotes Aging In Place. *Health Affairs*; Sep 1;35(9):1558-63.

How do we redesign structures to support new roles? → Practice

- Need to minimize role confusion by clearly defining competencies and then training for new functions
- Job descriptions have to be rewritten or created
- Work flows have to be redesigned
- Lack of standardized training and funds to support training is big obstacle
- Existing staff won't delegate or share roles if they don't trust that other staff members are competent
- Time spent on training is not spent on billable services

How do we redesign structures to support new roles? ⇨ Regulation

> *"The workforce innovations needed to implement ACA programs require an adaptable regulatory system capable of evolving with the health care environment. The health profession regulation system in place today does not have the flexibility to support change*

- To create a more dynamic regulatory system, we need to:
- develop evidence to support regulatory changes, especially for new roles
- evaluate new/expanded roles to understand if interventions improve health, lower costs and enhance satisfaction (patient and provider)

Source: Dower C, Moore J, Langelier M. It is time to restructure health professions scope-of-practice regulations to remove barriers to care. *Health Aff* (Millwood). 2013 Nov;32(11); Fraher E, Spetz J, Naylor M. Nursing in a Transformed Health Care System: New Roles, New Rules. LDI/INQRI Research Brief. June 2015.

Reframe #4: From a sole focus of IPE on students in pipeline to concurrently retooling and retraining the existing workforce

Old School

- IPE – primarily redesign curriculum for pre-licensure in foundational education to be "collaboration-ready"

New School

- New models of continuing professional development and interprofessional clinical learning environments support retooling the current workers already in the health care system for new models of care at the same as preparing the future workforce.

We need to better connect education to practice

> *"Revolutionary changes in the nature and form of health care delivery are reverberating backward into…education as leaders of the new practice organizations demand that the educational mission be responsive to their needs for practitioners who can work with teams in more flexible and changing organizations…"*

- But education system is lagging because it remains largely insulated from care delivery reform
- **Need closer linkages between health care delivery and education systems**

Source: Ricketts T, Fraher E. Reconfiguring health workforce policy so that education, training, and actual delivery of care are closely connected. *Health Aff* (Millwood). 2013 Nov;32(11):1874-80.

2015: Interprofessional Learning Continuum of Framework

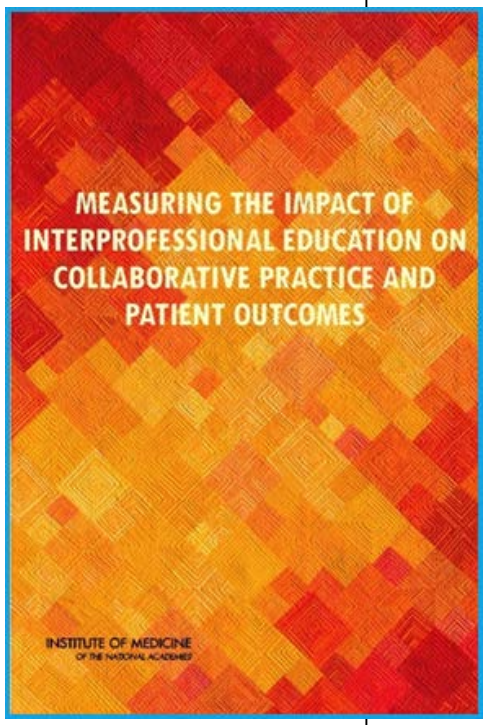
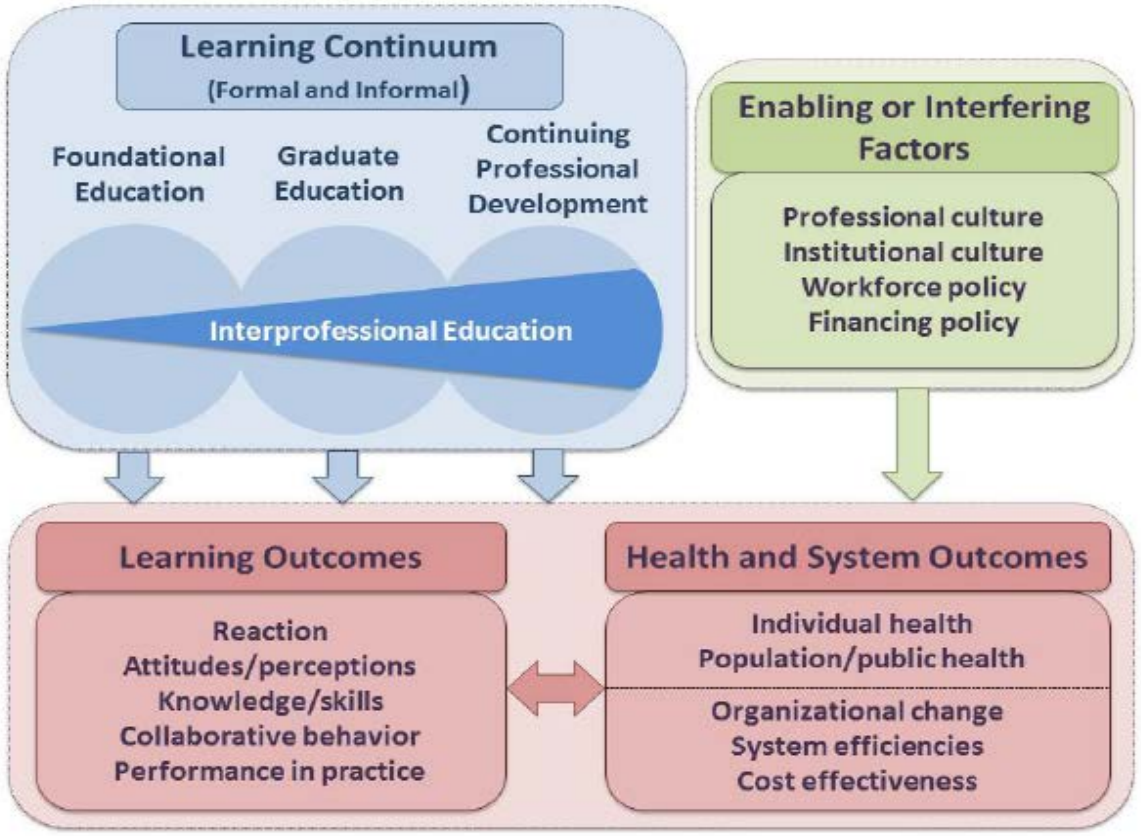


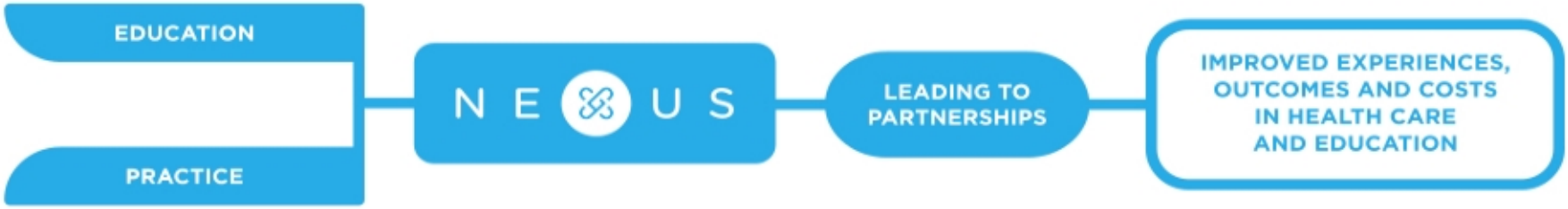
FIGURE: The interprofessional learning continuum (IPLC) model



NOTE: For this model, "graduate education" encompasses any advanced formal or supervised health professions training taking place between completion of foundational education and entry into unsupervised practice.

Source: Figure 3.2 in: IOM (Institute of Medicine). 2015. *Measuring the Impact of Interprofessional Education on Collaborative Practice and Patient Outcomes.* Washington, DC: The National Academies Press.

The Nexus: Our Vision for Health
nexusipe.org



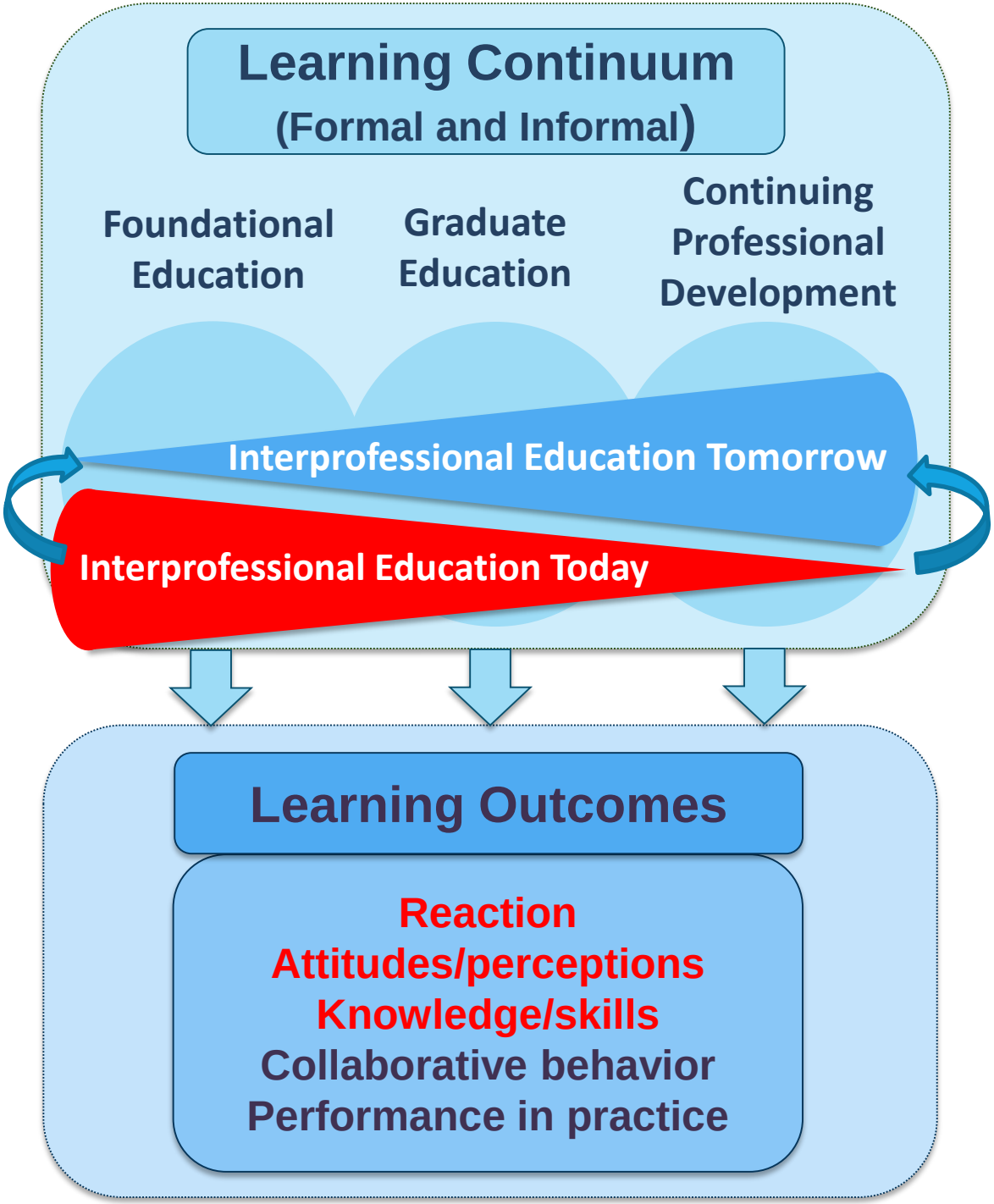
Triple Aim of Alignment

Improving quality of experience for patients, families, communities and learners

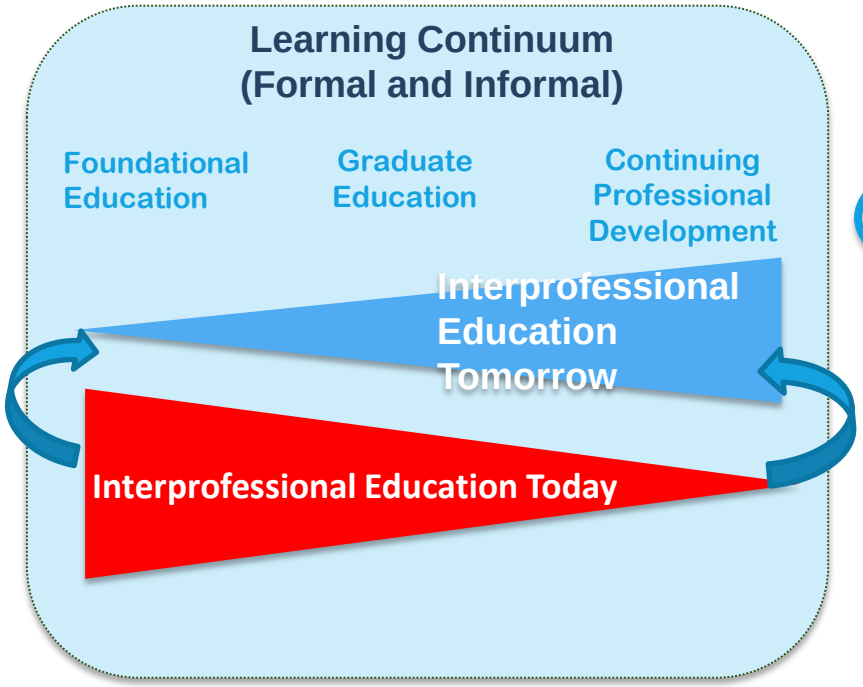
Sharing responsibility for achieving health outcomes and improved learning

Reducing cost and adding value in health care delivery and education

Quadruple Aim response


Learning Continuum
(Formal and Informal)
Foundational Education
Graduate Education
Continuing Professional Development
Interprofessional Education Tomorrow
Interprofessional Education Today
Learning Outcomes
Reaction
Attitudes/perceptions
Knowledge/skills
Collaborative behavior
Performance in practice

The ‘Reverse Megaphone’ Effect



The majority of IPE efforts today occur **early** in the learning continuum (Foundational Education) resulting in lower level learning outcomes (reaction, attitudes/perceptions and knowledge/skills).

The greatest opportunity for collaborative practice is when students/trainees are working together in clinical practice, where relationships are formed and interdependence is readily evident.

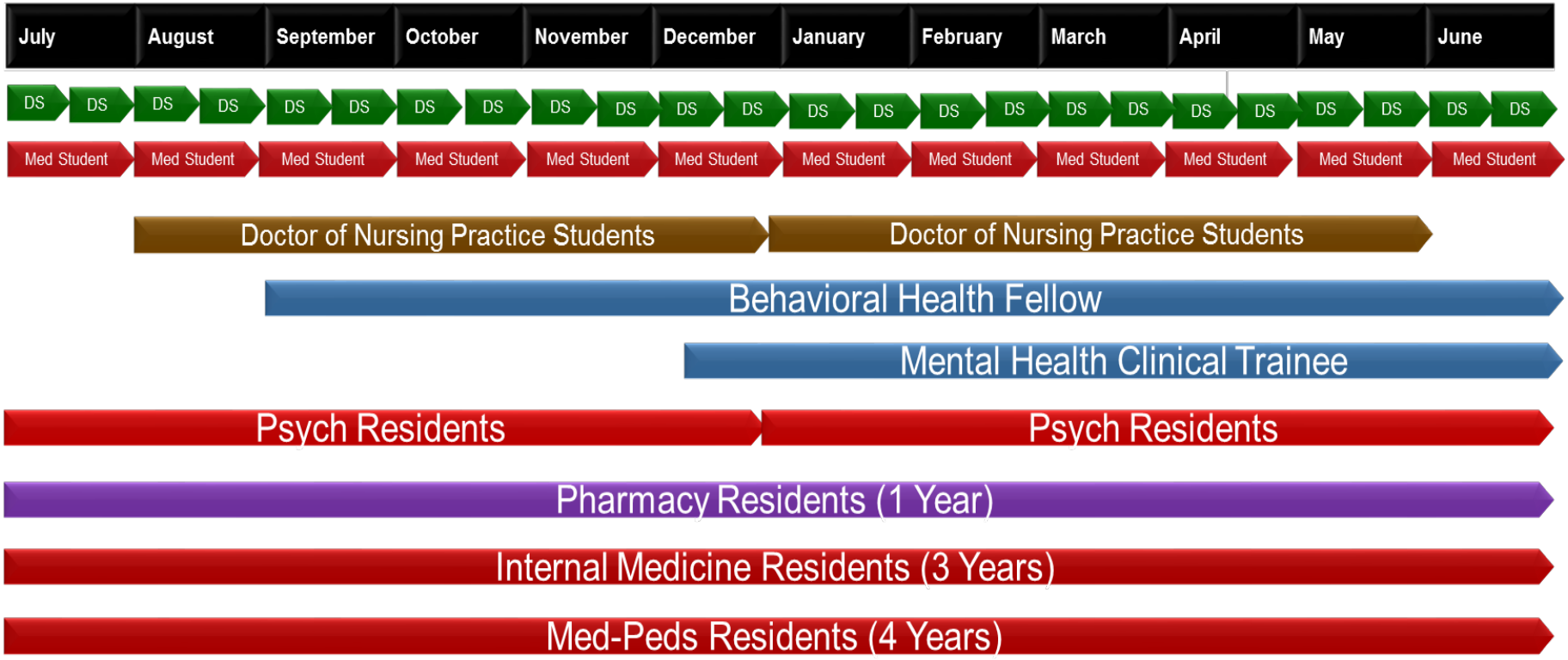
If the ultimate goal of IPE is to improve health and system outcomes, education & training should increase across the learning continuum.

At best, there is only a weak connection between formal classroom-based IPE and improved health or systems outcomes.

The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25067. The National Center is also funded in part by the Josiah Macy Jr. Foundation, the Robert Wood Johnson Foundation, the Gordon and Betty Moore Foundation and the University of Minnesota.

Nexus:
Aligning IPE & Clinical Practice Redesign

Academic Tourism: Types and Duration of Educational Experiences in one FQHC



DS: Dental Student
Med Student: Medical students. Includes students from 7700, 7701, and 7511
Doctor of Nursing Practice (DNP): Includes those specializing in Psychiatry, Pediatrics, Family Practice, and Midwifery

Communications Intern

Legal Intern

UNIVERSITY OF MINNESOTA

Community-University Health Care Center

Reframe #5: From accreditation standards focused on a single profession to incorporating the importance of team-based care.

Old School

- Accreditation standards for individual professions are viewed as barriers to IPE.

New School

- Accreditation standards require IPE and team-based competencies and move toward common frameworks for IPE and IPCP across professions.

National Center as Unbiased, Neutral Convener

FOR IMMEDIATE RELEASE

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May 2, 2017

Health Professions Accreditors Collaborative Welcomes 17 New Member Organizations

Chicago, IL – The Health Professions Accreditors Collaborative (HPAC) is pleased to welcome 17 accrediting organizations as new members of the Collaborative. The new members join the six founding members of HPAC: Accreditation Council for Pharmacy Education, Commission on Collegiate Nursing Education, Commission on Dental Accreditation, Commission on Osteopathic College Accreditation, Council on Education for Public Health, and the Liaison Committee on Medical Education. This move expands the composition of HPAC to 23 organizations committed to working together to advance interprofessional education (IPE), practice, and quality, as well as working together on other educational and research issues of common interest. The new accreditor members are:

- Accrediting Bureau of Health Education Schools
- Accreditation Commission for Education in Nursing
- Accreditation Commission for Midwifery Education
- Accreditation Council for Education in Nutrition and Dietetics
- Accreditation Council on Optometric Education
- Accreditation Review Commission on Education for the Physician Assistant
- American Psychological Association Commission on Accreditation
- Commission on Accreditation of Allied Health Education Programs
- Commission on Accreditation of Athletic Training Education
- Commission on Accreditation for Health Informatics and Information Management Education
- Commission on Accreditation in Physical Therapy Education
- Commission on Accreditation for Respiratory Care
- Council on Academic Accreditation in Audiology and Speech-Language Pathology
- Council on Accreditation of Nurse Anesthesia Educational Programs
- Council on Chiropractic Education
- Council on Podiatric Medical Education
- Council on Social Work Education

NCICLE NATIONAL COLLABORATIVE FOR IMPROVING THE CLINICAL LEARNING ENVIRONMENT

Envisioning the Optimal Interprofessional Clinical Learning Environment:

INITIAL FINDINGS FROM AN OCTOBER 2017 NCICLE SYMPOSIUM

NCICLE: Untying the Interprofessional Gordian Knot

- Important that Medicine convenes and invites others to co-lead
  - 100 years of history, tradition and culture
  - Medicine has the ear of policy makers.
- It's about culture
- Complex, wicked problems cannot be solved by technical solutions.
- IPE research has lived on the margins
- New models of IP research

Reframe #6: From limited evidence that IPE benefits learners to commitment to collecting evidence for IPE and IPCP on learning and health outcomes.

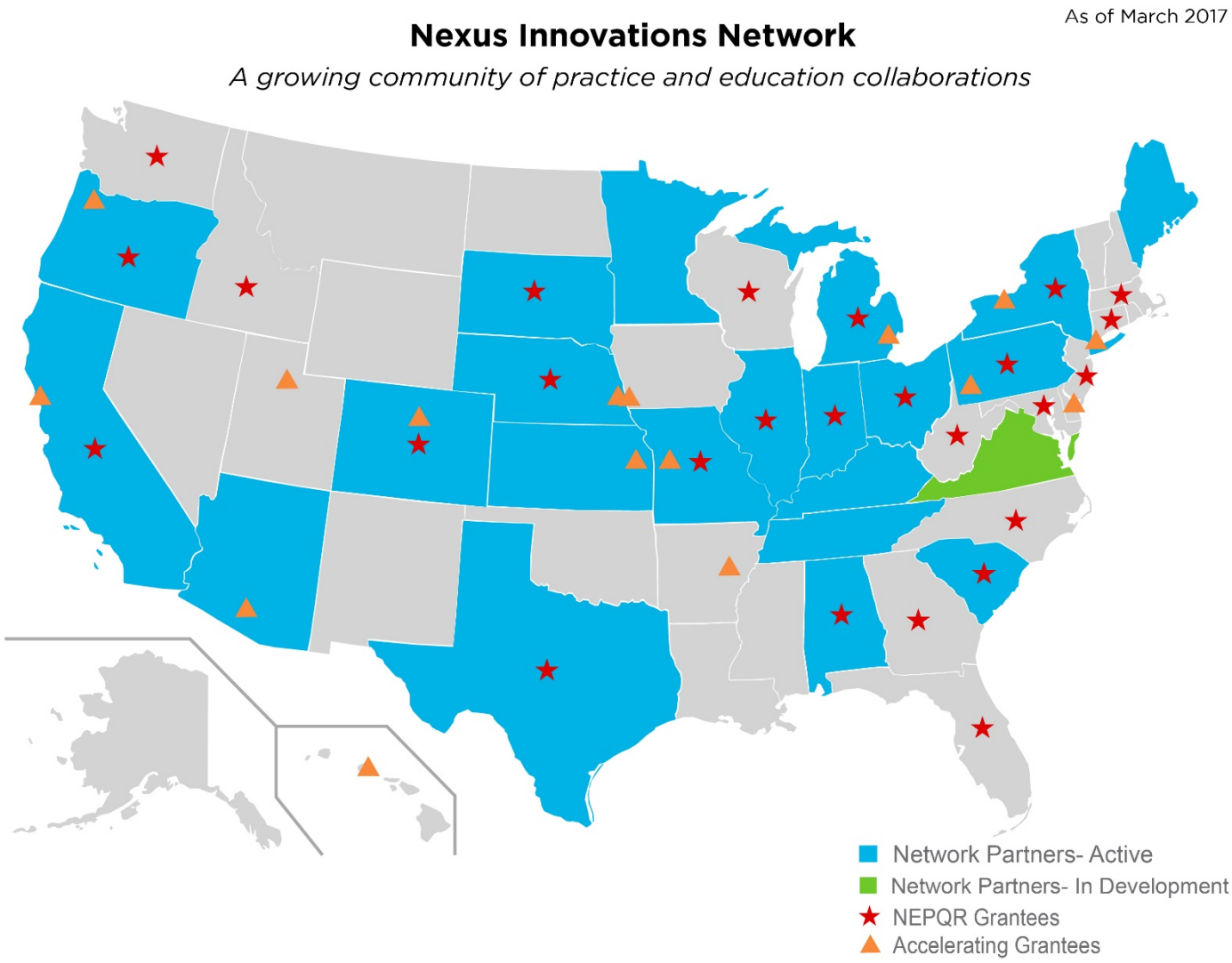
Old School

- Resistance to change based upon perceived lack of evidence for teams and IPE.

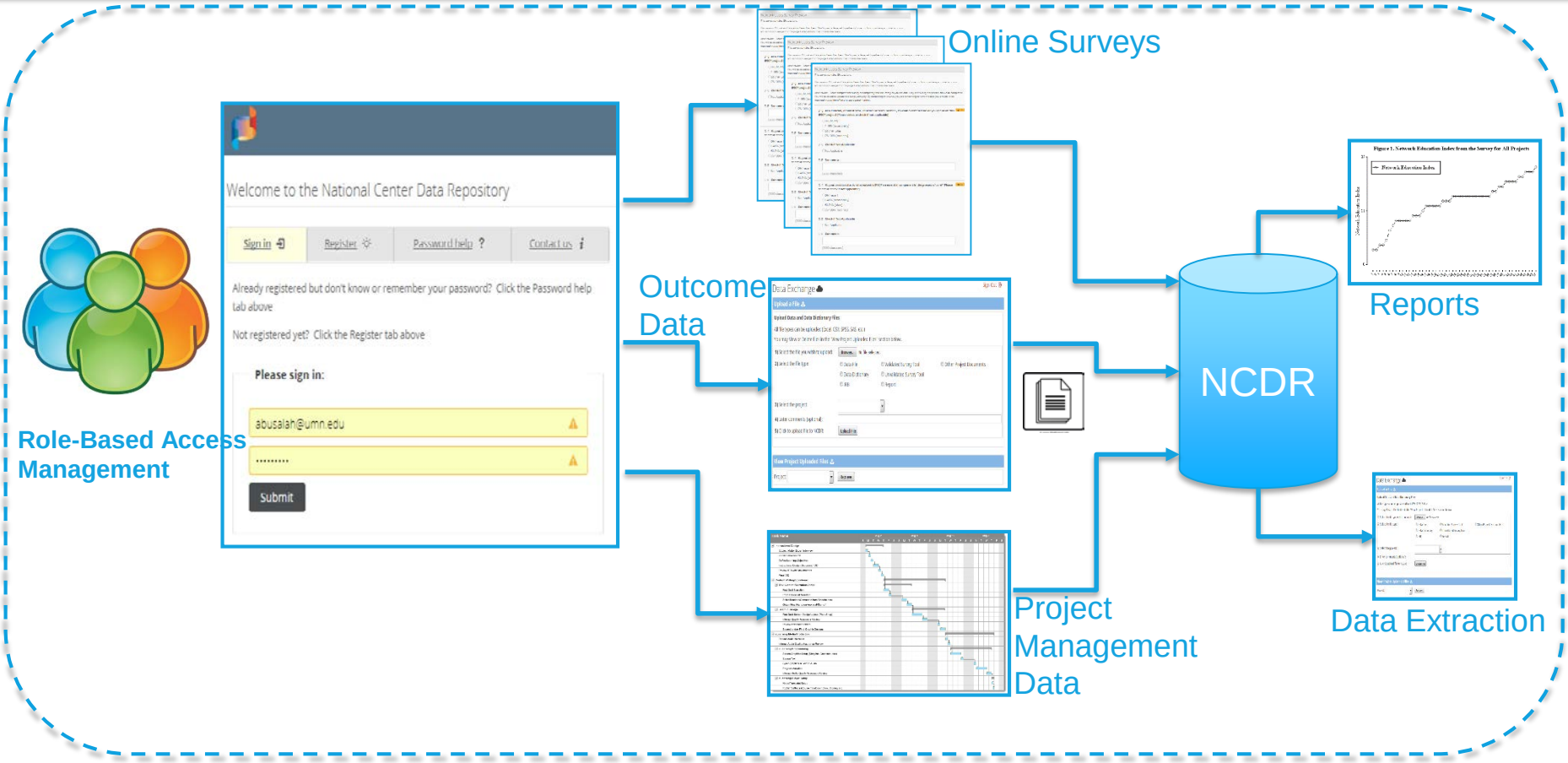
New School

- Commitment to rigorous research methods in IPE, leading to growing evidence base that is used to redesign interprofessional practice and education to achieve the Triple Aim.

Nexus Innovations Network: Participation Map



National Center Data Repository (NCDR) Data Infrastructure



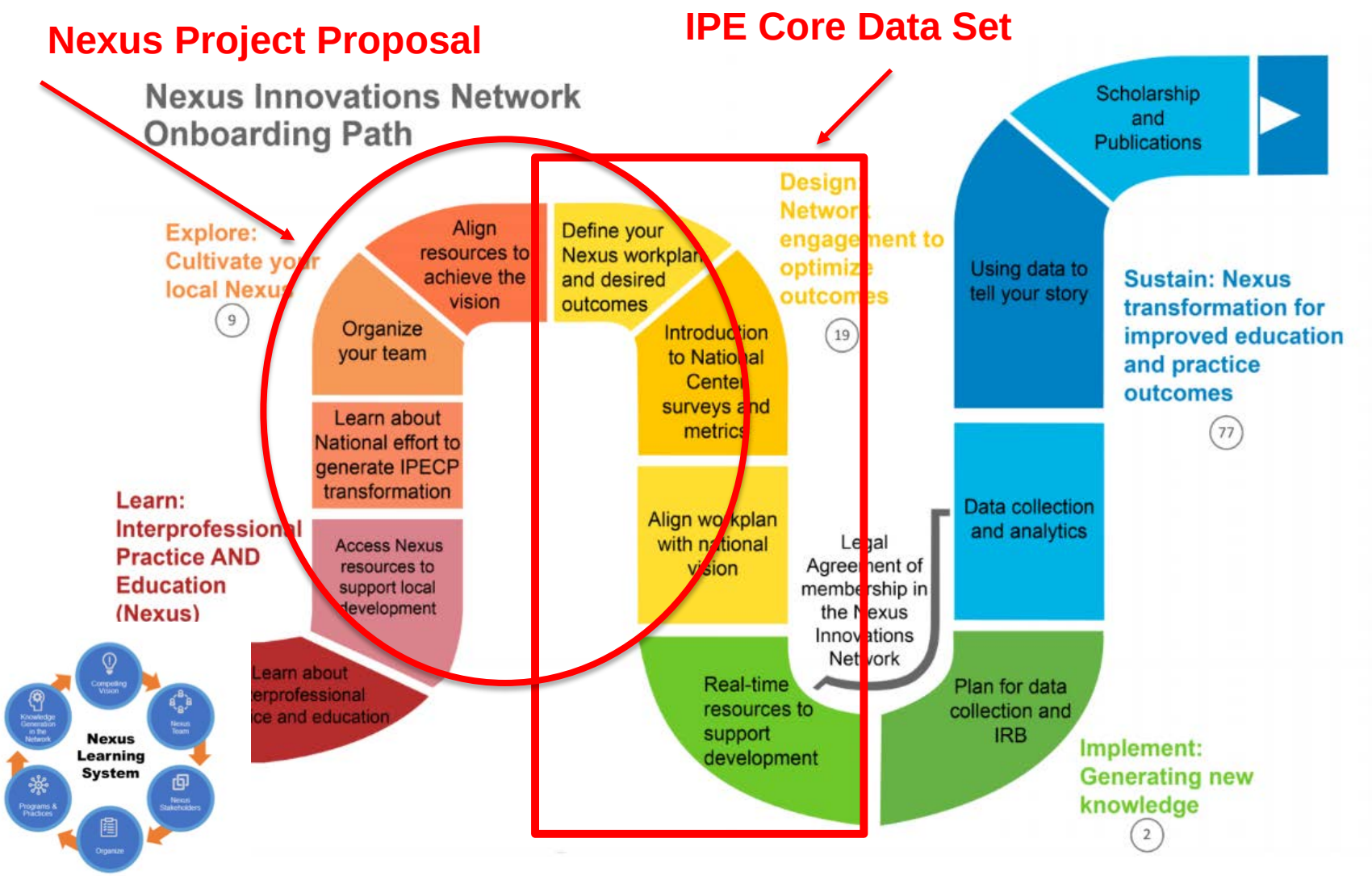
PHI Compliant Environment || Secure Data Transfer & Storage || Role-Based Access || Encrypted DB

Compliant with IRB || Health Info Privacy & Compliance Office || Center of Exc. for HIPAA Data

What's in the IPE Core Data Set?

- learner outcomes,
- educational learning environment,
- clinical learning environment,
- population health,
- provider wellbeing,
- patient experience, and
- use of health services (cost)

Restructuring the Network Onboarding Process



What We've Learned: Emerging Critical Success Factors

Process of care redesign is about changing culture.

Compelling vision is required.

IP+E resourcing is critical.

Senior leadership is essential.

Impressions of team training effectiveness are mixed.

The Application of Informatics in Delineating the Proof of Concept for Creating Knowledge of the Value Added by Interprofessional Practice and Education. Healthcare 2015, 3, 1158-1173.

April 4-5, 2018, Minneapolis
Nexusipe.org

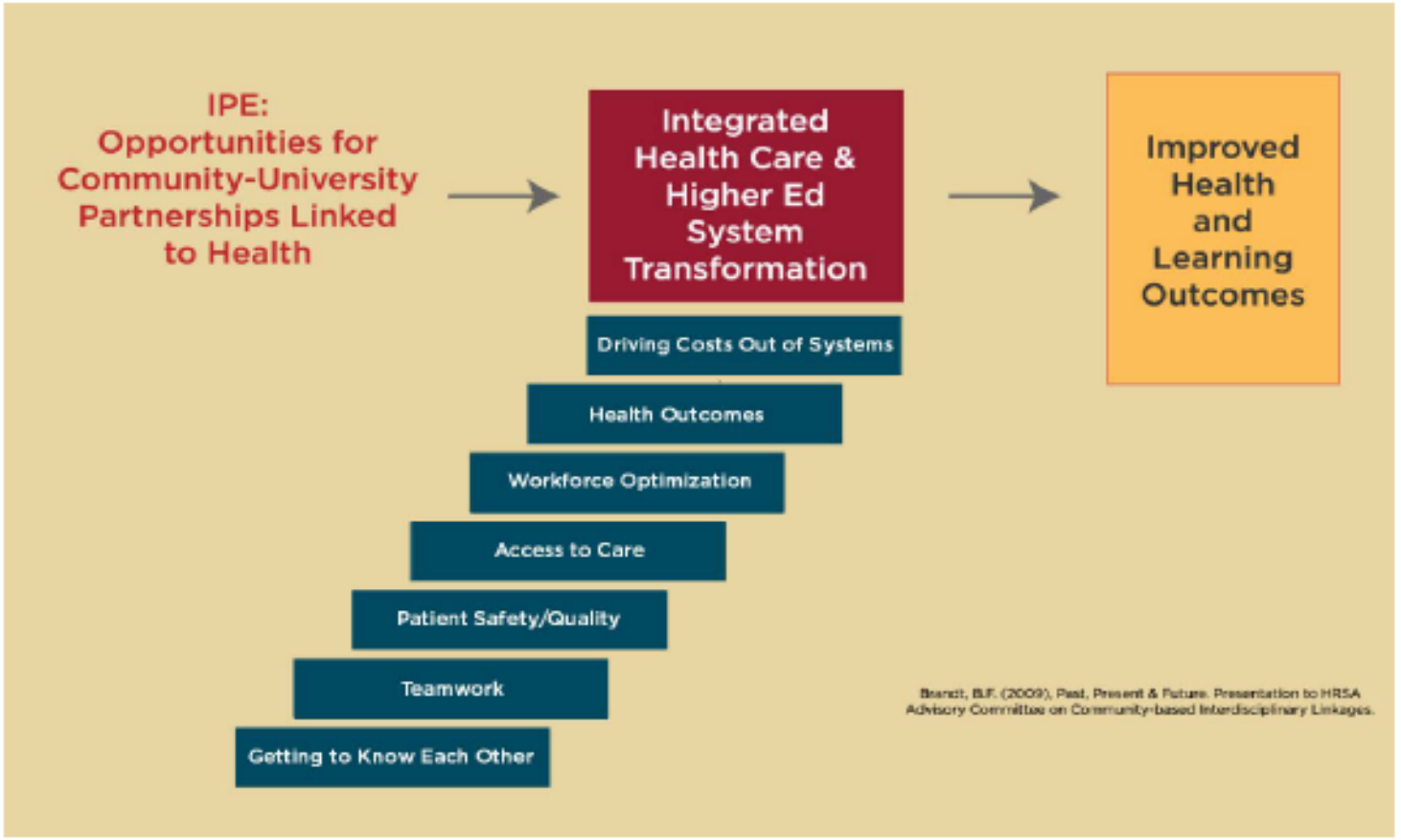
Hands-on **informatics/big data** workshop designed to provide a laboratory to address the key issues facing attendees. The workshop will teach **key concepts**, highlight **exemplars**, provide **group consultations** and **customize** the work session to address the questions brought forward by attendees.

Nexus Learning System Tools to Use

Version 2.2

Realizing Our Vision as a Team: National Center for Interprofessional Practice and Education Stairstep Model

Using the Stairstep Model (2009) as a tool, this session is meant to storyboard your project's highest possible future. After reviewing the model and worksheet, follow subsequent instructions to build a storyboard detailing your progress and path.



The National Center for Interprofessional Practice and Education is supported by a Health Resources and Services Administration Cooperative Agreement Award No. UE5HP25047. The National Center is also funded in part by the Josiah Macy Jr. Foundation, the Robert Wood Johnson Foundation, the Gordon and Betty Moore Foundation, The John A. Hartford Foundation and the University of Minnesota.

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Version 2.2

What is Our Team's Nexus Developmental Stage?

Date:

Please indicate the nature of IPE implementation at your site / institution today (check all that apply).

Stair	Key Tasks	Extent to which this is currently occurring				
		Significant extent	Moderate extent	Some extent	Slight extent	Not at all
1. Getting to Know Each Other	Convene key stakeholders to get to know each other as a pre-requisite for successful IPE.					
2. Teamwork	Intentionally teach teamwork knowledge, skills, and attitudes/values.					
3. Patient Safety/ Quality	Purposefully use IPE to teach/learn about and address patient safety and quality issues.					
4. Access to Care	Strategically implement IPE as a means to improve access to health care.					
5. Workforce Optimization	Move from teaching to learning with increasing emphasis on experiential and workplace learning.					
	Incorporate IPE into health workforce redesign efforts for new models of care.					
6. Health Outcomes	Intentionally link IPE efforts to improve individual, population, and/or community health outcomes.					
7. Driving Costs Out of Systems	Develop and implement IPE models so that they lower costs in health care.					
	Develop and implement IPE models so that they lower costs in education.					

UNIVERSITY OF MINNESOTA

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NATIONAL CENTER for INTERPROFESSIONAL PRACTICE and EDUCATION

Version 1.0 October 2016

Co-Write Your Nexus Story

Where have you been?	Where are you now?

Think about and document the current "as-is" state of your Nexus today. Consider:

- What is the state of your Nexus team?
- What is the history and current funding of the program?
- How supportive is the leadership?

Journal and reflect on your Ne

Think Big, Start Small

Design Your Highest Possible Future in IPE?
Where do you want to be in 2020? 2025?
What are the headlines? What is going on at the system level?
What is going on in the practice and in the education program/

Nexus Innovations Network Intervention Project

Nexus Innovations Network Intervention Project

NATIONAL CENTER for INTERPROFESSIONAL PRACTICE and EDUCATION

Designing Our Future – Strengths, Opportunities, Aspirations, Results, Resources?

As a team, use the NC-SOARR framework to guide your discussion as to how you will provide meaningful results for your Nexus project. Then, use the general reflection questions as prompts for collaborative future thinking about how your team will implement IPE.

Resources: What do we need to get the results we want from our IPE effort? *How are we going to garner them?*

Results: What will be the outcomes? What will have changed as the result of IPE? *How will we know we've reached it?*

Aspirations: What is the best possible future for our *IPE program? What will it look like in 1Year? 5 years?*

Opportunities: *What possibilities do we see? What can we do differently?*

Strengths and Assets: *What do we do well? What current assets (people, resources, courses) do we have to implement IPE?*

General Reflection: What are we learning from this exercise? What does it mean? What actions should we take to get the results we want? Summarize the team experience with the SOARR exercise.

Cooperrider, D.L., Whitney, D., & Stavros, J. (2008). The appreciative inquiry handbook (2nd ed.). San Francisco, CA: Berrett-Koehler

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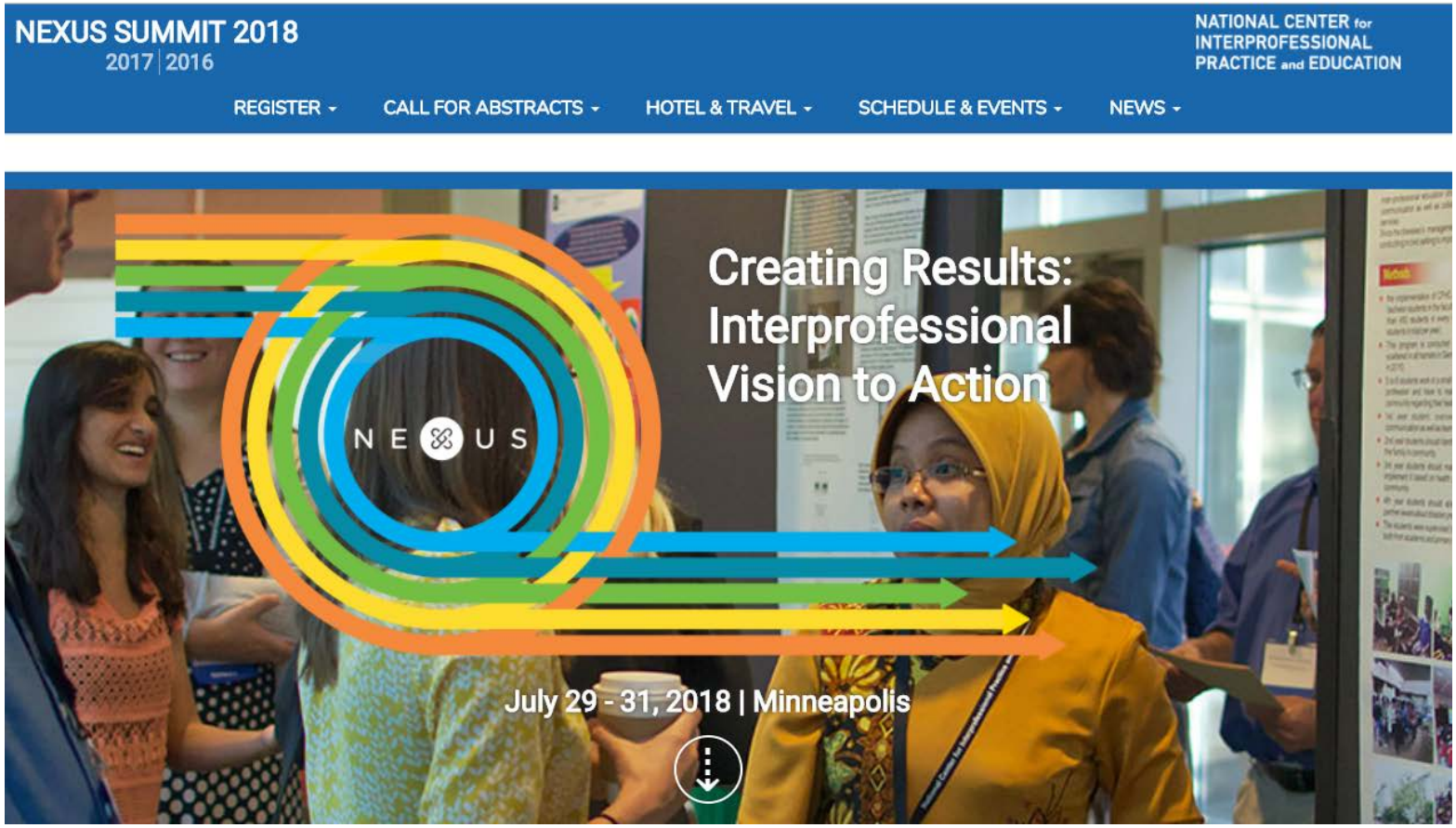

Thank you

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