Shaping the Clinical Learning Environment to Meet the Evolving Needs of the Health Care System and Patients

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This presentation in one slide

- My frame – I am a workforce researcher and policy wonk

- The context—lots of uncertainty, lots of pressure and rapidly changing payment and care delivery models

- The health workforce is shifting to ambulatory and community-based settings. Training needs to shift as well

- Efforts to redesign education have traditionally focused on pipeline. We also need to retool the existing workforce for new roles and settings

- Education, practice and regulatory changes are needed to support team-based models of care

- More and better data are needed to win hearts and minds

This is noble, challenging work that is rife with turf battles. Here is my "frame"

- I am a student of the health professions—all professions

- I believe in patient-centered, not profession-centered, workforce planning

- "Data agitator"—I like to use data to challenge prevailing narratives and to shape new narratives

- Policy wonk who believes deeply in power of evidence to shape policy

- I teach and mentor learners from medicine, nursing, social work, and health policy

The context for our work: lots of uncertainty, lots of pressure and rapid change

- Ongoing experimentation underway to transform the way health care is paid for, organized, and delivered

- Rising pressure to contain costs, increase value and address "upstream" social determinants of health

- Increased competition from corporate players like CVS, DispatchHealth, CityBlock, and Amazon who are using redesigned workforce, telehealth and house calls to meet patient needs (they get it...it's about the patient!)

- Most hospitals and health care systems currently operating predominantly in fee-for-service model, but actively planning for value-based payment future
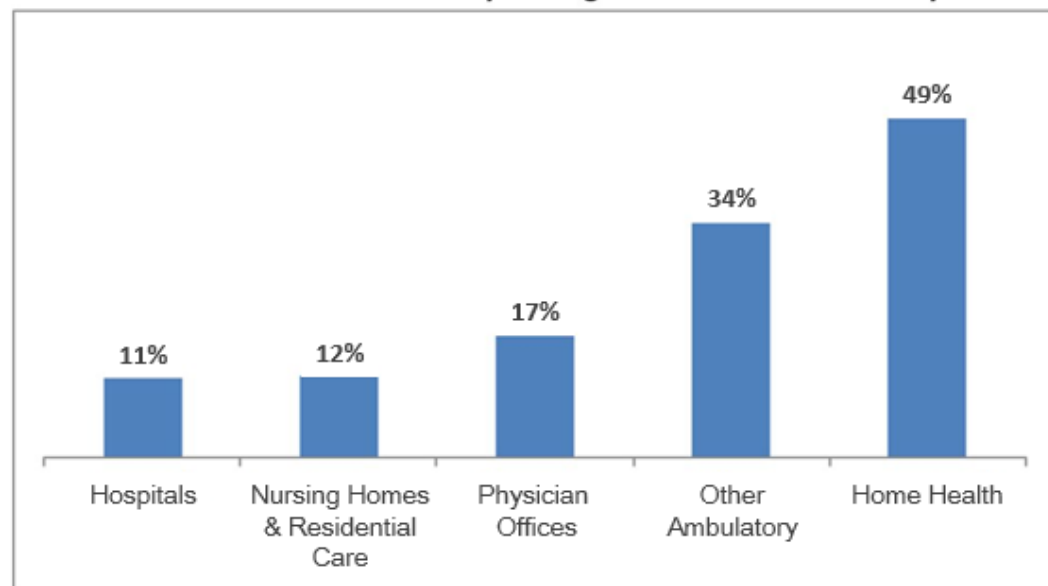
It sort of feels like this…

Hospitals, health systems and practices are simultaneously uninterested in workforce planning and hungry for a roadmap on how to redesign care delivery and workforce to deliver value

That road map leads out of the hospital into outpatient, community and home settings

- Shift from fee-for-service to value-based payments and fines that penalize hospitals for readmissions are shifting care from inpatient to ambulatory and community-based settings

- But we generally train the workforce in inpatient settings

- Need to develop more interprofessional training sites in community-based settings

Exhibit 1: Health Care Job Growth by Setting: December 2007–January 2017

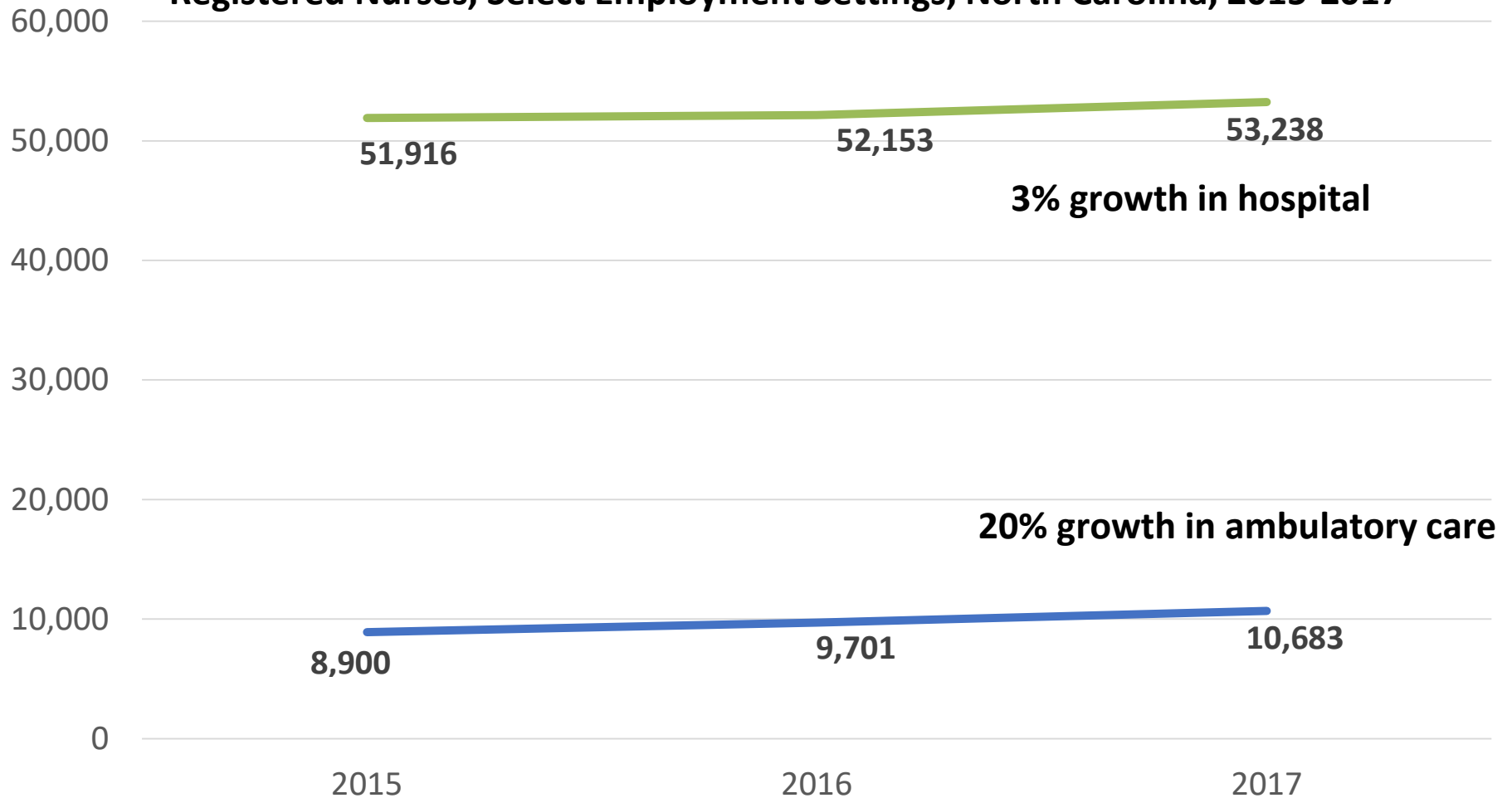|				
11%	12%	17%	34%	49%
Hospitals	Nursing Homes & Residential Care	Physician Offices	Other Ambulatory	Home Health

Source: Authors' analysis of BLS Current Employment Statistics data.

Turner A, Roehrig C, Hempstead K. What's Behind 2.5 Million New Health Jobs? *Health Affairs* Blog. March 17, 2017.
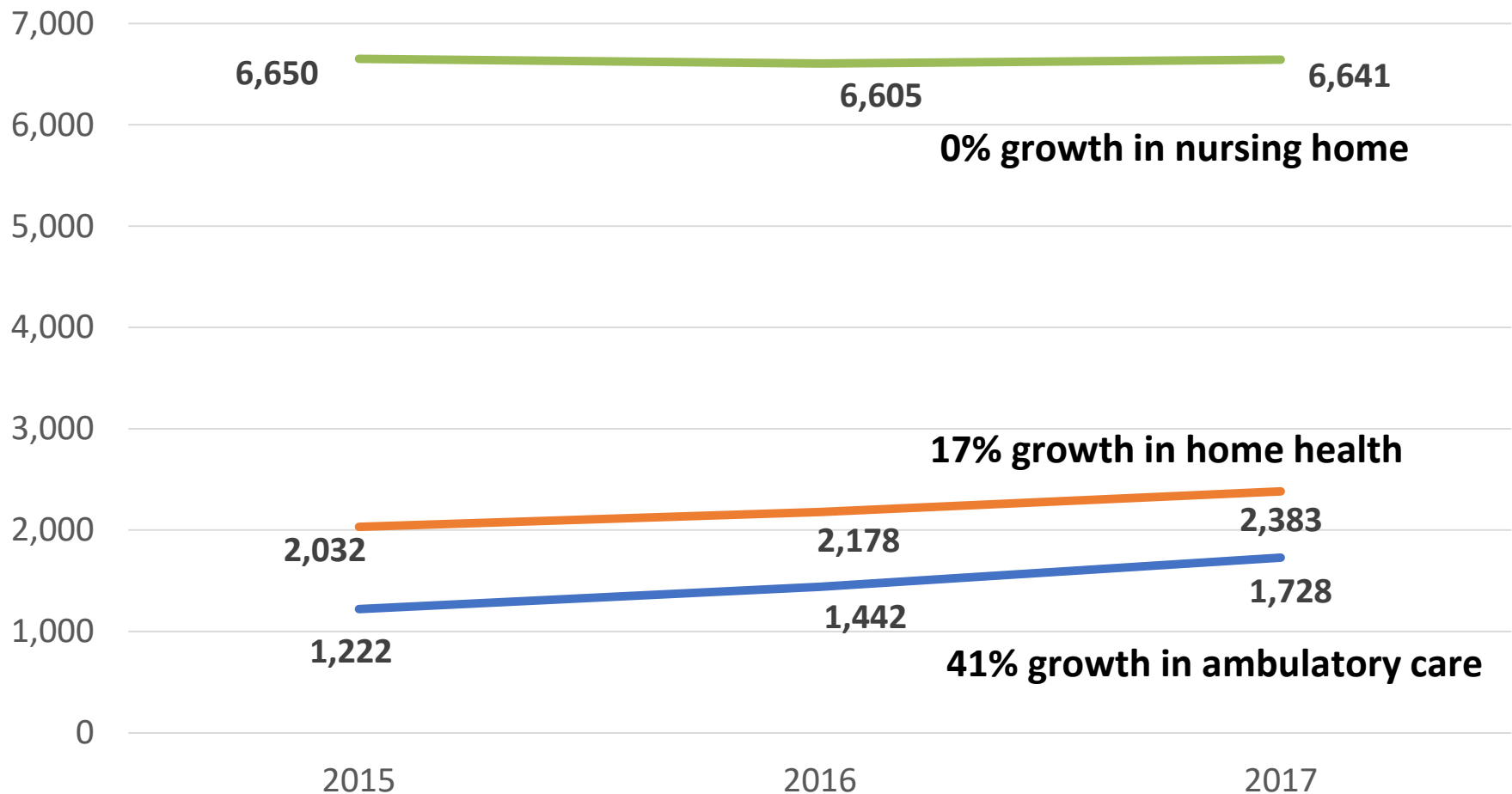http://healthaffairs.org/blog/2017/03/17/whats-behind-2-5-million-new-health-jobs/

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About half of RN workforce in NC is employed in hospitals but ambulatory care jobs are increasing rapidly

Registered Nurses, Select Employment Settings, North Carolina, 2015-2017

51,916   52,153   53,238

3% growth in hospital

20% growth in ambulatory care

8,900   9,701   10,683

2015   2016   2017

About one-third of LPN workforce in NC is in nursing homes but rapid growth in ambulatory care and home health

Licensed Practical Nurses, Select Employment Settings, North Carolina, 2015-2017

Nursing home: 6,650 (2015), 6,605 (2016), 6,641 (2017) — **0% growth in nursing home**

Home health: 2,032 (2015), 2,178 (2016), 2,383 (2017) — **17% growth in home health**

Ambulatory care: 1,222 (2015), 1,442 (2016), 1,728 (2017) — **41% growth in ambulatory care**

Increased focus on social determinants of health is moving care upstream

- Shift narrative from health workforce to "workforce for health"

- Expand workforce planning efforts to include workers in home- and community-based settings

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

- Integrated behavioral health and primary care models are spawning new team structures and new roles.
  Example: social workers who are serving as:

  - Behavioral health specialists: providing interventions for mental, behavioral health and substance abuse disorders

  - Care Managers: coordinating, monitoring and assessing treatment plans

  - Referral role: connecting patients to community resources, transportation, food

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And don't forget that the patient, family and community are on the team

Patient-engagement models:

- Promote shared decision-making with patient and family

- Encourage providers to do more asking/listening and shift from telling to educating

- Focus on health literacy, coaching, goal setting, and teach-back methods

- Honor and validate work of caregivers and family

- Include faith-based institutions, legal aid and other community resources

Increasing recognition that workforce already employed in the system will be the ones who transform care

- Most interprofessional education focused on redesigning curriculum for students in pipeline

- But health care workforce *already employed in system* will transform care

- Need to embed learning in collaborative practice environments that benefit patients, learners and the health care system

Number of Health Professionals in the Workforce Versus New Entrants to the Workforce, Select Professions, 2012

Profession	Total workforce	New entrants	New entrants as a percentage of total workforce
Physicians	835,723	21,294[a]	2.5%
Physician assistants	106,419	6,207	5.8%
Registered nurses	2,682,262	146,572	5.5%
Licensed practical nurses and licensed vocational nurses	630,395	60,519	9.6%
Dentists	157,395	5,084	3.2%
Chiropractors	54,444	2,496	4.6%
Optometrists	33,202	1,404	4.2%
Social workers	724,618	41,769	5.8%
Physical therapists	198,400	10,102	5.1%
Occupational therapists	90,483	6,227	6.9%

Fraher E, Ricketts TC. Building a Value-Based Workforce in North Carolina. *North Carolina Medical Journal*. 2016; 77(2): 94-8.
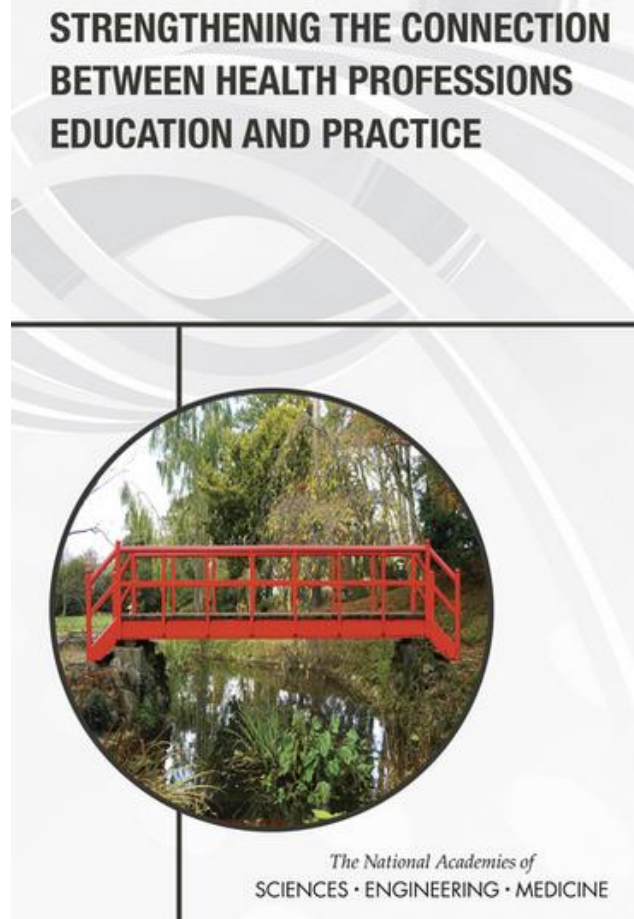
So how do we get there from here?

We need to redesign the broader system that supports interprofessional education and practice through:

- Education

- Practice

- Regulation

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…"

STRENGTHENING THE CONNECTION BETWEEN HEALTH PROFESSIONS EDUCATION AND PRACTICE

The National Academies of
SCIENCES · ENGINEERING · MEDICINE

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.

http://www.nationalacademies.org/hmd/Reports/2019/strengthening-connection-between-health-professions-education-practice-proceedings.aspx

Redesign structures to support team-based care ➡ Education

- Clinical rotations need to include "purposeful exposure" to high-performing teams in ambulatory and community settings

- Foundational and continuing education must be convenient – timing, location, and financial incentives must be taken into consideration

- Need to prepare faculty to teach new roles and functions

- Close partnerships between educators and employers needed to:

  - not produce more workers than market demands

  - ensure new grads are ready for practice in transformed system

  - identify professions, settings and roles in which the workforce over- and under-skilled

Redesign structures to support team-based care ⟹ **Practice**

- Need to design teams around patients, not professions

- Job descriptions must be rewritten or created

- Workflows must be redesigned

- Minimize role confusion by clearly defining competencies and training for new functions

- Existing staff won't delegate or share roles if don't trust other staff members are competent

- Culture change *is possible* as successful models spread and are scaled

Redesign structures to support team-based care ➡ 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 in interprofessional teams

- evaluate new/expanded roles to understand if interventions improve health, lower costs and enhance satisfaction (patient and provider)

We need data and rigorous analyses to win the hearts and minds of the IPE naysayers

Team-based care for patients with 2 or more chronic conditions produced a statistically significant reduction of:

- 18.6% in hospitalizations

- 25.2% in ED visits

- 36.7% in ambulatory care–sensitive emergency department visits

JAMA Internal Medicine | Original Investigation

Association of Team-Based Primary Care With Health Care Utilization and Costs Among Chronically Ill Patients

David J. Meyers, MPH; Alyna T. Chien, MD, MS; Kevin H. Nguyen, MS; Zhonghe Li, MS; Sara J. Singer, MBA, PhD; Meredith B. Rosenthal, PhD

+ Invited Commentary
+ Supplemental content

IMPORTANCE Empirical study findings to date are mixed on the association between team-based primary care initiatives and health care use and costs for Medicaid and commercially insured patients, especially those with multiple chronic conditions.

OBJECTIVE To evaluate the association of establishing team-based primary care with patient health care use and costs.

DESIGN, SETTING, AND PARTICIPANTS We used difference-in-differences to compare preutilization and postutilization rates between intervention and comparison practices with inverse probability weighting to balance observable differences. We fit a linear model using generalized estimating equations to adjust for clustering at 18 academically affiliated primary care practices in the Boston, Massachusetts, area between 2011 and 2015. The study included 83 953 patients accounting for 138 113 patient-years across 18 intervention practices and 238 455 patients accounting for 401 573 patient-years across 76 comparison practices. Data were analyzed between April and August 2018.

EXPOSURES Practices participated in a 4-year learning collaborative that created and supported team-based primary care.

MAIN OUTCOMES AND MEASURES Outpatient visits, hospitalizations, emergency department visits, ambulatory care–sensitive hospitalizations, ambulatory care–sensitive emergency department visits, and total costs of care.

RESULTS Of 322 408 participants, 176 259 (54.7%) were female; 64 030 (19.9%) were younger than 18 years and 258 378 (80.1%) were age 19 to 64 years. Intervention practices had fewer participants, with 2 or more chronic conditions (n = 51 155 [37.0%] vs n = 186 954 [46.6%]), more participants younger than 18 years (n = 337 931 [27.5%] vs n = 74 691 [18.6%]), higher

Meyers DJ et al. Association of Team-Based Primary Care With Health Care Utilization and Costs Among Chronically Ill Patients. JAMA Intern Med 2019 Jan 1;179(1):54-61. doi: 10.1001/jamainternmed.2018.5118.

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And we need to be prepared to discover data that run counter to our hopes and expectations

That same JAMA Intern Med study concluded:

"Team-based care practice transformation in primary care settings may be a valuable tool in improving the care of sicker patients, thereby reducing avoidable use; however, it may lead to greater use among healthier patients"

Meyers DJ et al. Association of Team-Based Primary Care With Health Care Utilization and Costs Among Chronically Ill Patients. JAMA Intern Med 2019 Jan 1;179(1):54-61. doi: 10.1001/jamainternmed.2018.5118

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