Welcome! The Program will begin at 8:00 a.m.
Welcome to the Nexus Summit 2019!

Barbara F. Brandt
Director and Co-Chair
The Clinical Learning Environment: Where Practice and Education Collide And Shape the Future of Health Care

Erin Fraher
University of Carolina
Council on Graduate Medical Education

Laurinda Calogne, EdD, MeD, MSW
Our Lady of the Lakes Regional Medical Center

Michael Apostolakos, MD, FCCP
University of Rochester Medical Center

Debra Albert, RN
University of Chicago Medicine
Shaping the Clinical Learning Environment to Meet the Evolving Needs of the Health Care System and Patients

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Associate Professor, Department of Family Medicine
Director, Carolina Health Workforce Research Center
University of North Carolina at Chapel Hill

NexusSummit2019
National Center for Interprofessional Practice and Education
August 19, 2019
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


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

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

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

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

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...”


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
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

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”

Contact Information

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- 820 bed quaternary care medical center
- 84 medical residencies and fellowships
- Medical, dental, and nursing schools
- Trauma center
- Transplant center
- Cancer center
- Children’s Hospital
UR Pursuing Excellence

- ACGME Innovator grant
- Transforming the way clinical teams work
- Developing dyad leaders (faculty and nurse managers)
  - Year long training program
- Given skills and support to build collaborative improvement teams
  - Faculty, nurses, staff, trainees, etc.
- Built on foundation of UPP teams
- Goal to develop clinical leaders who can lead improvements in team-based, collaborative care within UR Medicine, and enrich the learning environment
  - This will improve patient outcome (value), improve provider and patient satisfaction, provide academic opportunity, and develop our leaders of the future
UChicago Medicine: The System

Patients and Facilities
- 4 Adult & Pediatric hospitals
- 1,286 licensed beds
- 11 Ambulatory Care Facilities
- 2.21B Annual Revenue

Volume
- 45,300 Admissions
- 27,890 Operations
- 149,355 Emergency dept. visits
- 954,173 Outpatient Encounters

Providers and People
- 11,910 Employees
- 1,385 Attending physicians
- 1,132 Residents and Fellows
- 3,418 Nurses

Research and education are critically important
- 412 NIH grants totaling over $179M
UCM’s Hyde Park Campus and Hub

FACILITIES

3 Facilities
- Center for Care and Discovery
- Bernard M. Mitchell Hospital
- Comer Children’s Hospital

811 Licensed Beds

37 Operating Rooms

5 Ambulatory Care Facilities

VOLUME

<table>
<thead>
<tr>
<th>Volume</th>
<th>Description</th>
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<tbody>
<tr>
<td>602,517</td>
<td>Outpatient Encounters</td>
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<tr>
<td>31,577</td>
<td>Hospital Admissions</td>
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<tr>
<td>198,745</td>
<td>Hospital Patient Days</td>
</tr>
<tr>
<td>22,801</td>
<td>Surgical Cases</td>
</tr>
<tr>
<td>101,567</td>
<td>ER Visits</td>
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</table>

FINANCIALS

<table>
<thead>
<tr>
<th>Financials</th>
<th>Description</th>
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<tbody>
<tr>
<td>$1.86B</td>
<td>Operating Revenue</td>
</tr>
<tr>
<td>$477.3M</td>
<td>Community Benefit (fiscal 2018)</td>
</tr>
</tbody>
</table>

PEOPLE

9,737 Employees

Including:
- 909 Physicians
- 2,797 Nurses
- 1,132 Residents, fellows
IGNITE (Improving GME-Nursing Interprofessional Team Experiences) aims to engage trainees and nurses together in performance improvement initiatives at both the unit-level and the institutional level with the ultimate goal of improving healthcare delivery for our patients.

IGNITE UNIT-BASED TEAMS
- Unit-based teams comprised of GME trainees, nurse managers, & staff nurses co-design and implement a performance improvement project who receive support in the form of:
  - QI coaching/guidance from GME and hospital leaders
  - Ongoing project management and data analytic support
- We are currently operational in 6 units and seek to expand to at least 12 by 2020

IGNITE KAIZEN EVENTS
- Partnership between GME, Nursing, and Operational Excellence to sponsor up to 2 mini-Kaizen events yearly to improve care on institution-wide
- 3 Roles for trainees in any program include:
  - Kaizen Champion (3 day participant)
  - Voice of customer (1-3 hour participant)
  - Kaizen Liaison to GME program (Represent your program at report-out & report-back to your program)

ECLIPSE Educational & Clinical Leaders Improving Performance with Structured E3L training program for senior-level trainees, faculty, and clinical staff aims to increase the capacity of clinicians to lead local quality improvement projects through offering a certification in E3 Leadership.

WHAT IS E3 LEADERSHIP?
- E3 stands for “Engage, Evolve, Excel” and represents our local approach to achieve high reliability and deliver high value care based on Six Sigma principles
- UCM relies on our management system of E3 Leadership (E3L) to reduce process variation and improve quality

E3 LEADERSHIP CERTIFICATION REQUIREMENTS
- Complete five E3L training modules available online (including: E3L Overview, Standard Work, PDSA Problem Solving, Data Lab, and Leading a Project)
  
- Modules approved for AMA PRA Category 1 Credit™
- Participate in any Kaizen Event as a Kaizen Champion with an interprofessional team
- Pass a 30 question certification exam on E3 principles & standard performance improvement

VP Operational Excellence Greg Horner, GME Director Clinical Learning Environment Vinet Arora, and Chief Nursing Officer & SVP Patient Care Services Debra Albert co-sponsor IGNITE Kaizen events

The Japanese word kaizen means "change for better", with inherent meaning of either "continuous" or "philosophy"

改善
Kai = Change Zen = Good

改良
“Engage Evolve Excel
This event reinforced how standard work is best created by those performing the work”

-ECLIPSE Participant

ECLIPSE Steering Committee
OLOL – Pursuing Excellence

• TEAMWORK on the FLY
  • Bringing QI and IPE where education and clinical care merge.
  • IPE Huddles, Teaching, Shared Vision, and Positive Recognition

• It’s all in the HCAPS DATA
  + 45.2% Care Transitions – HCAPS YTD – 100%
  + 5.3% Discharge Information – HCAPS YTD – 100%
  + 23.4% Hospital Environment – HCAPS YTD – 100%
**MED 5: CUMULATIVE UNIT HARM SCORE**

Harm Score = Scope (4= All patients at risk; 3= 75% of patients at risk; 2=50% of patients at risk; 1=25% of patients at risk; 0=patients not at risk) + Impact (5=Loss of Life/Limb/Function; 4=Temporary loss of function; 3=Prolonged hospital stay; 2=Moderate Cohorting; 1=Minor harm; 0=No harm) + Harms (5=Falls; 4=CLABSI; 3=CAUTI; 2=HAPI; 1=MRSA; 0=C-Diff)
Discussion