Exploring a business case for workplaces as investing entities for high-value CPD

Stuart Gilman, Veterans Health Administration
Lucy Savitz, Intermountain Health Care
Case

- 5 VA facilities established a collaborative workgroup to use workplace learning strategies to prepare interprofessional clinical faculty/staff to teach PI to interprofessional trainees.
- Expert led conference calls followed by expert and collaborative peer coaching led to the participants learning to do/teach PI by each site improving low acuity use of Emerg Dept for empaneled primary care patients.
STAKEHOLDERS

• Patients
• Clinical Institution Senior Management
• Clinical Institution Mid Management
• Front line clinicians
• Front line staff
• Academic affiliates
• VACO Academic Affiliations
• Community representatives
OPTION DESCRIPTIONS

• Choices about what problems to tackle
• Choices about expected results of the activity
• Choices about instructional designs
• Choices about outcome measures to use
  – What unit(s) of analysis
  – Preferable to demonstrate patient outcomes
  – Multiple outcome measures: team knowledge, transference of skills in other circumstances
QUANTITATIVE COST-BENEFIT ANALYSIS

What sorts of costs go into designing and implementing this CPD intervention?

• Workplace-focused education likely involves educational costs/benefits and clinical environment costs/benefits.

• Development costs: faculty time, instructional design resources, data management resources....

• Implementation/Operational costs: participant time, facility costs, food, materials, transportation, time, staff support, lost clinical productivity, data management resources, simulation equipment, space, staff, clinical intervention costs....
## Workplace Education Cost/Benefit Table

### Prototype

<table>
<thead>
<tr>
<th></th>
<th>Education</th>
<th>Clinical</th>
</tr>
</thead>
</table>
| **Development** | • Faculty time curriculum development  
• Instructional design  
• Data management  
• Educational outcomes identified | • Clinical staff time for aim development, current state inquiry  
• Data management  
• Clinical outcomes identified |
| **Operation** | • Faculty time  
• Costs of educational intervention (e.g. technology, media, simulation....)  
• Data collection, management, analysis | • Clinical staff time for champions as well as all staff involved in clinical change  
• Patient out of pocket, time, parking, transportation....  
• Data collection, management, analysis |
What are the risks to the investing entity?

- Cost shifts
- Substitution risks- Doing more of one thing may lead to using less of something important.
- Liability: If new system seriously misperforms
- Unsuccessful educational process or clinical transformation generate cynicism
- Some interventions may be at odds with other improvement goals
Why would a workplace organization want to be an investing entity for high-value CPD?

– Needs to have an authentic impact on workplace operations for support of the high-value CPD. At least some of the outcome measures must focus on impact to facility (e.g. ED utilization).

– But we also need to have measures making the case for workforce development. Measures of learning outcomes and competencies, staff retention and recruitment optimally linked to real clinical performance.
QUANTITATIVE COST-BENEFIT ANALYSIS

What sorts of cost savings might be realized with its implementation?

• Patient education to help patients access care and to ultimately change patient behavior
• Possibly avoidance of maintenance cost (if it’s a 1-year plan)
• Reduction of burnout
• Retention of faculty & lower turnover, recruitment
• Higher satisfaction ratings
• Engagement by stakeholders (low engagement can lead to patient number reduction, meaning loss of money)
• Social capital
• Educational side:
  • Using technology (video recordings, for ex) to reduce costs of hiring faculty
  • Train the trainer approach
QUALITATIVE COST-BENEFIT ANALYSIS

What are the benefits to the investing entity?
• Improved quality/safety, reduction of waste....
• Prevention of burnout
• Patient satisfaction
• Interrelationship interventions
• Job enlargement- e.g. nursing where nurses’ roles are expanded in a clinical setting
• Measure engagement scores to track progress of patient acuity improvement

What are the benefits to other stakeholders?
• Clinical stakeholders- fiscal benefits e.g. time
• Diffusion outcomes e.g. skills gained can lead to better socio/societal outcomes
• Improved curriculum elements exported to other settings