Capstone Project:

Geriatric Interprofessional Education and Clinical Care:

Examining Sustainability of the U-Team at Walker Methodist

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Table of Contents

Executive Summary .......................................................................................................................... 3

Introduction ...................................................................................................................................... 5

Background, Context and Theoretical Framework ......................................................................... 7

Research Methodology .................................................................................................................. 21

Results ........................................................................................................................................... 24

  Stakeholder Analysis ..................................................................................................................... 24
  Strengths, Weaknesses, Opportunities and Challenges (SWOC) Analysis ................................. 30
  Logic Model ................................................................................................................................. 32
  Summary and Analysis of Results ............................................................................................... 33

Recommendations .......................................................................................................................... 38

Conclusion ....................................................................................................................................... 43

Bibliography .................................................................................................................................... 45

Appendices ....................................................................................................................................... 49

  Appendix A: Overview of the Education and Training of Professionals in Geriatrics
  Appendix B: Interviews completed
  Appendix C: Power versus Interest grid
  Appendix D: SWOC analysis worksheet
  Appendix E: Logic model
Executive Summary

Our population is rapidly aging. Over the next two decades, Americans over the age of 65 will increase from 39 million to over 70 million. Seniors, as a national share, will increase in population by six percentage points. In addition, roughly one in four Minnesotans will be over the age of 65 by 2030 and the number of people over 85 will triple. Yet, our health care system is largely unprepared for its social, humanitarian, and financial implications of the “silver tsunami” beginning to hit. One of those implications is a health care system ill-equipped to meet the needs of older adults.

The University of Minnesota’s Geriatric Interprofessional Teaching and Practice Team (U-Team) is uniquely positioned to respond to the health care needs of our aging population. The U-Team’s educational training program and clinical practice, located at Walker Methodist Health Care Center in Minneapolis, trains between 90-100 students each year from a variety of disciplines. In addition, the team provides excellent clinical care to patients, primarily in Walker’s dental clinic and in its Transitional Care Unit (TCU). Despite its rich history of providing high quality interprofessional geriatric training and clinical care, the program has encountered a number of challenges in recent years that have threatened the program’s sustainability.

Several challenges faced by the U-Team are common to similar programs. Namely, the interprofessional care model provides a significant departure from the traditional medical model common in the United States. As a result, organizational, financial and reimbursement structures do not align and work against the U-Team’s teaching and care model. Second, geriatrics programs across the country fail to receive the institutional focus they deserve, which is a
problem, particularly our changing demographics. As a result, the U-Team faces challenges related both to its interprofessional model and geriatric focus.

The program faces several additional challenges. First, the widespread economic downturn has negatively impacted funding streams previously provided to the program. Second, active support and engagement from participating academic departments and the Walker site has been mixed over time, with an important departmental co-sponsor recently withdrawing from the program. Finally, the current financial practices serve as a disincentive to the current model and undermine it.

As a part of a master’s capstone seminar, five graduate students from the Humphrey School of Public Affairs assisted the U-Team in identifying and addressing these issues. The student consultants (1) researched the partnership; (2) conduct a review of similar systems across the nation; (3) undertake a thorough, organizational, operational, and stakeholder analyses to (4) provide targeted recommendations, the results of which are as follows:

Step 1: Establish mechanisms for ongoing strategic and operational dialogue.

Step 2: Develop shared agreement among U-Team members, Walker leadership and participating departments (MOA)

Step 3: Develop an outreach strategy

Step 4: Ensure compatibility between U-Team and partner missions
Introduction

The University of Minnesota’s Geriatric Interprofessional Teaching and Practice Team (U-Team) is an educational training program and clinical practice located at Walker Methodist Health Care Center (Walker Methodist), a 488-bed skilled nursing facility located in Minneapolis. Despite its history of providing high quality interprofessional (IP) geriatric training to students representing a variety of disciplines, as well as of providing excellent clinical care, the program has encountered a number of challenges in recent years that have threatened the program’s sustainability.

First, financial pressures brought on by the widespread economic downturn have negatively impacted funding streams available to the program, including those previously provided by the state to support the training of medical residents, as well as those allocated to the program by the University of Minnesota’s Academic Health Center. Second, although several University departments benefit from the program through the specialized geriatric training provided to health students, the ability and willingness of participating departments to continue their involvement has been mixed. Most recently, the School of Nursing, which played a central and important role in leading the IP program, withdrew, largely for financial reasons. It is possible that a general lack of recognition and support of geriatrics has contributed to the tenuous nature of support from stakeholders.

Third, current payment systems create a financial disincentive for the IP model of education and care the team provides. Although the U-Team’s clinical practice has been shown to lead to improved clinical outcomes and cost savings (Blewett et al., 2004), the benefits of
these savings are largely received by the federal government and insurers, rather than by Walker or by participating academic departments. Finally, the program’s absence of operational and administrative support has negatively affected the U-Team’s capacity to proactively plan to sustain or expand its programming. The program currently lacks operational and strategic plans and does not fully maximize opportunities to market its innovative model and important work.

Faced by these multiple challenges, the U-Team obtained the assistance of five students from the University of Minnesota’s Humphrey School of Public Affairs, who undertook this work as their final master’s capstone project. In collaboration with the U-Team, the student consultants (we) researched the challenges facing the program with the aim of helping the program to become more sustainable. To accomplish this, we read background materials about the U-Team’s history and accomplishments, completed interviews with program faculty and other key stakeholders, reviewed extant literature related to geriatric and interprofessional education and clinical practice, and consulted with a variety of individuals with expertise related to aspects of our project. We also examined the U-Team’s current methods of measuring impact and communicating value, as well as worked with our clients to complete several exercises intended to create a starting point for their ongoing strategic planning work, including a “strengths, weaknesses, opportunities and challenges” (SWOC) assessment, stakeholder analysis, and logic model. Following a description and discussion of the results of our research activities, we formalize several recommendations to our client, which are aimed at strengthening the U-Team’s relationships with stakeholders, as well as improve its long-term sustainability.
Background, Context and Theoretical Framework

Description of the U-Team

The U-Team’s interprofessional geriatric program, which has actively engaged students and patients since 2003, trains clinical students representing various health disciplines to care collaboratively for older adults. The team’s teaching and clinical activities take place within a large skilled nursing facility in Minneapolis, several miles from the University of Minnesota. Through its educational and clinical activities, the U-Team provides both innovative, high quality clinical care, as well as a setting for student-clinicians to work in a team-oriented fashion to assess, share resources, and set therapeutic goals for Walker patients and residents. Not only do students learn about geriatrics, but also about interprofessional collaboration.

The U-Team’s interdisciplinary faculty includes geriatrician Teresa McCarthy, MD (Medical School), dentist Stephen Shuman, DDS (School of Dentistry), pharmacist Shellina Scheiner, PharmD (College of Pharmacy), all board-certified regular faculty at the University of Minnesota, as well as dental hygienist Peg Simonson (School of Dentistry), who is also an important member of the teaching and clinical team. Additionally, the U-Team is strengthened by the involvement of chiropractor Paul Osterbauer, DC, faculty with Northwestern Health Sciences University and chaplaincy instructors from Luther Seminary in St. Paul, as well as a nurse practitioner employed by Fairview Health System. Although the nurse practitioner participates in interprofessional clinical activities and the team’s weekly IP grand rounds, her position with Fairview prevents her from participating in teaching activities.
GERIATRIC INTERPROFESSIONAL EDUCATION AND CLINICAL CARE

The U-Team’s teaching and clinical activities occur primarily within Walker Methodist’s 44-bed transitional care unit (TCU), where many of the facility’s most complex patients receive care. The TCU provides short-term post-acute care, which allows residents to transfer from the hospital to residential setting (e.g., home, assisted living, or long-term care). Patients cared for by the U-Team receive more specialized, focused care than do other patients. For students, the TCU setting provides an opportunity to gain a robust understanding of the complexities of geriatric care in a way that encourages collaboration and shared learning.

Through the interprofessional educational program between 90 and 100 students are trained each year, although faculty members are exploring ways to expand this number to reach more trainees. The training site at Walker Methodist is the largest provider of experiential interprofessional education in geriatrics in the state and serves as a model for interprofessional and geriatrics education and service throughout the state and nationally.

Literature Review

In the following sections, we review relevant literature related to the challenges and opportunities faced by our client. Specifically, we discuss the implications of the aging population, training of health professionals adequately prepared to provide care to older adults, interprofessional training and practice, and theoretical frameworks that help guide our work.

Aging Population and Related Health Care Needs

The first baby-boomers turned 65 in 2011. Over the next two decades, the number of Americans over the age of 65 will increase from 39 million to over 70 million (American Geriatric Society, 2012). Nationally, the proportion of seniors is expected to increase from 13 percent to 19 percent over this same period. In Minnesota, the projections are even more
startling. By 2030, roughly 24 percent of the state’s population will be over 65. Moreover, the number of Minnesotans over 85 will nearly triple from 90,000 as of 2010 to 250,000 by 2050 (Minnesota Department of Health, 2005).

Not only is the population continuing to age rapidly, but individuals are living longer. In 2000, there were approximately 72,000 Americans living to 100 years; by the middle of the century that number will skyrocket to 834,000 (Krach and Velkoff, 1999). Increased awareness of issues such as heart disease, smoking and exercise, combined with advancements in medical technology, contribute to this longevity (Cutler et al., 2007). Compared to other segments of the population, older adults have more complex health care needs (Wieland, 1996) and consume a disproportionate amount of health care resources (Bardach and Rowles, 2012). Although many adults remain healthy throughout their older years, others represent the “epidemic of chronic disease” (Anderson and Horvath, 2004). Twenty percent of Medicare recipients have at least five chronic health conditions (American Geriatrics Society, 2012). Currently, 1.6 million residents live in the country’s 6,500 skilled nursing facilities and approximately 10 million seniors with moderate to severe disabilities need some level of long-term care (Miller et al., 2008).

**Geriatrics Workforce and Training**

Despite the “silver tsunami” beginning to hit, our health care system is largely unprepared. The availability of health care professionals adequately trained to address the health care needs of older adults lags behind reality (Bardach and Rowles, 2012; Mezey et al., 2008; Wieland, 1996). In 2005, there was only one geriatrician for every 5,000 Americans over age 65 (American Geriatrics Society, 2012) and that number is decreasing, as fewer physicians pursue
geriatrics (Alliance for Aging Research). According to the Institute of Medicine (2008), less than four percent of social workers specialize in geriatrics and even fewer, less than one percent, of nurses, pharmacists and physician assistants do.

In addition to the current shortage of professionals trained to meet the needs of older adults, our educational system is largely failing to train the next generation of geriatric practitioners. Inadequate geriatric training exists in medicine, nursing, pharmacy, dentistry, physical therapy and communication studies and few programs require geriatric rotations (Bardach and Rowles, 2012). Several factors contribute to this shortage. First, the current lack of geriatric health professionals has led to a lack of educators prepared to train the next generation. Relatedly, current educational options for geriatrics are limited. For example, only one-third of baccalaureate nursing programs require students to complete a course in geriatrics (Mezey et al., 2008) and out of 145 medical schools in the United States, only five departments are devoted to geriatrics with some teaching hospitals requiring internists to complete as few as six hours of geriatric training (Alliance for Aging Research, 2004; Gross, 2006).

Slowly, steps to address this incongruence are being made, perhaps in recognition of the significant and growing need for professionals with the training and background to care for our aging population. The percentage of medical schools that require some level “geriatric exposure” has increased from 82 percent in 1986 to 98 percent in 1997 (Eleazer et al., 2005) and a small number of programs, such as the University of Alabama at Birmingham (UAB) provide more intensive training to future geriatric clinicians (UAB website). At UAB, external funding from The John A. Hartford Foundation supports a geriatric medicine fellowship, which provides intensive year-long training to three physicians each year. Still, the level of training in the care
of older adults is likely not sufficiently thorough (Bardach & Rowles, 2012). Fifty-five percent of medical school graduates indicate they received inadequate geriatric training and only 68 percent report feeling knowledgeable enough to care for an elderly adult in an acute care setting (Association of American Medical Colleges, 2002).

Another confounding factor is the reality that geriatric practitioners often earn considerably less than clinicians in other specialties (see Appendix A). For example, the average salary for a geriatric physician is only $150,000, compared to $400,000 for a radiologist (Gross, 2006). Mounting student debt contributes to the pressure on health professionals to increase their earnings through more lucrative specialties. Similarly, despite their role as “linchpin of the formal health care delivery system for older adults” (IOM, 2008, p. 199) direct care workers, who provide the majority of care to older adults in long-term care settings, face extremely low wages. Hourly wages for nursing assistants, home health aides and personal/home care aides range from $8.54 to $10.67 (IOM, 2008), roughly what one would earn working in a fast food restaurant.

**Interprofessional Health Training and Practice**

The term “interprofessional” is increasingly being used to refer to the shared knowledge and “cohesive practice” of professionals representing different disciplines (D’Amour and Oandasan, 2005). According to the World Health Organization (2010), interprofessionality involves learning “about, from, and with each other to enable effective collaboration and improve health outcomes.” The goals of IP training include the achievement a distinct set of competencies including an understanding of the roles and responsibilities of one’s self and others, effective IP communication, and the ability to engage meaningfully with others in
patient-centered problem-solving (Robert Wood Johnson Foundation, 2011). The impacts of interprofessional education and practice can include improved patient, student, professional, organizational and system outcomes, as well as heightened job satisfaction (D’Amour and Oandasan, 2005).

Within the United States, interdisciplinary health care teams developed in the mid-1950s, primarily in fields such as mental health and rehabilitation that required a fair amount of coordination between disciplines (Fulmer et al., 2005). In geriatrics, IP teams emerged in the 1970s, both in response to the complexity of the patient populations being served as well as to increasing complexities of the health care system (Wieland, 1996; Reuben et al., 2004). Early adopters of team practice models tended to be affiliated with academic institutions or Veterans’ Administration (VA) medical centers (Wieland, 1996). With the first geriatric IP teams largely located in acute hospital settings, two team practice models soon developed: one focused primarily on shortening the length of patient hospital stay and another, focused on improving “patient function at discharge” (Wieland, 1996, 658).

In 1997, The John A. Hartford Foundation provided funding to eight academic institutions and community-based organizations, including the University of Minnesota, to support the development of Geriatric Interdisciplinary Team Training (GITT) programs (Fulmer et al., 2005). Through the GITT programs, 1,341 health professionals were trained in interdisciplinary geriatric practice. Although GITT did not change the “traditional model of clinical training at seven of the eight programs” (Fulmer et al., 2005, p. 466), trainees showed positive changes in attitudes toward teamwork, as well as increased confidence in their own clinical abilities (p. 468). At Rush University in Chicago, one of the original GITT sites, a
vibrant IP geriatric program still exists, with twelve disciplines collaborating to provide a program based on 10 weeks of classroom instruction coupled with placement at one of several clinical sites.

Interprofessional care teams have been associated with positive patient outcomes in a variety of settings (Wieland, 1996) and growing evidence suggests that team care can lead to improved clinical outcomes and patient satisfaction (Lemieux-Charles and McGuire, 2006; Reeves et al., 2009). A review of 128 studies showed geriatric IP teams led to improved patient quality of life and function, as well better overall quality of care (IOM, 2008). Because of its attendance to the complex, “multidimensional aspects of health in treating chronically ill and frail elderly” (Wieland, 1996), IP training and practice in geriatrics may be particularly important. In recent years, IP teams are increasingly looked to as a means of providing effective care for individuals with complex health care needs, including older patients (John A. Hartford Foundation, 2011; WHO, 2010; Clark, 1997; Fulmer et al., 2005).

In addition to meeting the needs of increasingly complex patient populations, other factors suggest IP training and practice is preferred. Health and economic system complexities, financial pressures (Lemieux-Charles & McGuire, 2006; WHO, 2010; Summers et al., 2000; Loxley, A., 1997) and a shortage of health care professionals (WHO, 2010) have necessitated looking to more efficient, effective ways of providing health care and education, such as through interprofessional care models (WHO, 2010). In fact, the World Health Organization (WHO) recently began urging international policymakers to look to interprofessional practice and education as a strategy to address the worldwide shortage of health workers, particularly within
the context of increasingly complex—and diverse—health systems and patient populations (2010).

**Challenges associated with IP approach**

Despite the trend toward IP models of training and care, there are several challenges associated with this approach. First, for many practitioners, the interdisciplinary approach marks a new endeavor and can be a challenging new way of practicing (WHO, 2011). Second, considerable differences between programs can make generalizing lessons learned in one setting to another difficult (WHO, 2010). Relatedly, the true impact of IP teams can be difficult to measure because teaching and clinical activities take place within the context of broader programs (Wieland, 1996). Third, the shortage of health professionals adequately trained to care for geriatric patients limits the sustainability of IP programs (Wieland, 1996). Fourth, current financial and reimbursement structures do not adequately support IP models of care, making operationalizing and sustaining such teams difficult (Wieland, 1996). Finally, because many current IP training and practice teams are associated with academic institutions that have been negatively impacted by the financial crisis, many geriatric IP teams increasingly face—or have faced—financial cuts.

**Program sustainability**

Several factors positively impact sustainability of IP programs. First, the support and “managerial commitment” of institutions involved is an essential foundational component to ensure program success (Stone, 2007). Without administrative support at the institutional level, it can be difficult, if not impossible, to make needed changes in IP education and practice (D’Amour & Oandasan, 2005). Further, given the formidable challenges facing geriatrics,
focused institutional commitment is also needed to bolster the workforce prepared to care for older adults. For example, a cornerstone of the University of Alabama’s successful geriatric training program is the focused effort of participating departments to support both fellows and junior faculty to develop into future clinicians. Funding, available through a collaborating VA medical center and the Southeast Center of Excellence in Geriatric Medicine (SCEGM) helps make this happen.

A second factor essential to the success of IP programs is open and consistent communication (WHO, 2010). Communication is essential to facilitate and maintain relationships between individuals and organizations involved. Third, a shared vision of the benefits of IP training is critical (WHO, 2010). Particularly in programs (such as the U-Team’s) that involve both education and practice, it is important to distinguish between “educational initiatives to enhance learner outcomes and collaborative practice to enhance patient outcomes” (D’Amour & Oandasan, 2005, p. 11). Finally, a champion who is responsible for coordinating educational activities and identifying barriers to progress is vital (Freeth, 2005).

Theoretical Frameworks

Interprofessional Education for Collaborative Patient-centered Practice

In many ways, the movement toward interprofessional learning and practice is being led by a group of Canadian educators in Toronto. Based on their experiences with launching and systemizing interprofessional training for health students at the University of Toronto, the group has proposed a framework, the “Interprofessional Education for Collaborative Patient-centered Practice (IECPCP) model,” (D’Amour & Oandasan, 2005) to illustrate the necessary
The interrelationship between interprofessional education and clinical practice. The model also identifies factors, or “levels of influence,” necessary for interprofessional models to succeed and be sustained. These factors include the following:

- **Micro factors** – which refers to the “teaching factors” or “learning context” in which IP education takes place (13).
- **Meso factors** – which describes the institutional context, such as level of organizational commitment, resources available to support program activities, etc. (13-14)
- **Macro factors** – which points to systemic factors, such as legislative and regulatory actions or realities, which can either hinder or facilitate IP education and practice (18).

According to the IECPCP model, two interdependent systems, educational and professional, continually interact. As can be seen in the following model, the student/learner is at the center of the first system and the patient at the center of the second. The two systems are impacted by factors at the micro, meso and meso levels, as well as by each other.

Despite their interrelationship, recognizing the distinction between the goals and outcomes of the educational and professional systems is necessary to win the understanding and support of various groups of stakeholders (D’Amour & Oandasan, 2005). For example, learner competencies related to IP practice should be clearly recognized and differentiated from patient outcomes that result from interprofessional care they receive.

Finally, the model is helpful in that it highlights the broader context in which IP teaching and practice activities occur. An IP team’s success depends not only on the communication, interdependence and teamwork of team members, but also on the broader organizational and system context. In order for the U-Team to succeed, factors at all three system levels need to
support the model. In addition, support is needed from a wide range of stakeholders: practitioners, educational systems, policymakers and the public (19).

Reframing organizations

A conceptual framework described by Bolman and Deal (2003) is also useful for examining the sustainability of the U-Team. Specifically, the authors discuss the power of “framing” in organizational work. In short, having reliable mental frameworks can help us make sense of complex and overwhelming situations or problems. However, the frames from which we operate can also be limiting. The authors detail a four-frame model, which includes structural, human resource, political and symbolic frames (16).
### Overview of the Four-Frame Model

<table>
<thead>
<tr>
<th>Frame</th>
<th>Structural</th>
<th>Human Resource</th>
<th>Political</th>
<th>Symbolic</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Metaphor for organization</strong></td>
<td>Well-oiled machine</td>
<td>Relationship based Family</td>
<td>Power driven Jungle</td>
<td>Inspiring carnival, temple, theater</td>
</tr>
<tr>
<td><strong>Central concepts</strong></td>
<td>Rules, roles, goals, policies, technology, environment</td>
<td>Needs, skills, relationships</td>
<td>Power, conflict, competition, organizational policies</td>
<td>Culture, meaning, metaphor, ritual, ceremony, stories, heroes</td>
</tr>
<tr>
<td><strong>Image of leadership</strong></td>
<td>Social architecture</td>
<td>Empowerment</td>
<td>Advocacy</td>
<td>Inspiration</td>
</tr>
<tr>
<td><strong>Basic leadership challenge</strong></td>
<td>Attune structure to task, technology environment</td>
<td>Organizational and human needs</td>
<td>Develop agenda and power base</td>
<td>Create faith, beauty, meaning</td>
</tr>
</tbody>
</table>

(Bolman and Deal, 2003, 16)

Traditionally, the clinical field has operated primarily under the structural frame, focusing on rules, coordination and efficiency (44-45). Key themes in the structural model include differentiation, or how work is divided among employees (49) and integration, or how to coordinate group efforts. Thus, within health professional contexts (such as nursing homes or other sites of clinical practice), individual roles have been well defined, with clear lines of authority and distinctions between professional groups. Differentiation between employee shifts and departments is clear. Such structural understanding has also influenced how the various academic departments—and Walker—have treated the U-Team, and how the U-Team has viewed itself.

The structural frame may be inadequate when managing a program like the U-Team, however. The U-Team needs to be effective in areas that go beyond programmatic activities. For example, more focus in the political, human resource, and symbolic frames could positively impact the program’s sustainability.
In the political frame, outreach to advocacy organizations and individuals with local, regional and national influence could provide the U-Team with a base of support for legislative advocacy and heightened public awareness. The political frame could also help identify windows of opportunities through which the U-Team can advance its agenda (i.e. “coupling” support for interdisciplinary geriatric care with “sexy initiatives,” such as the state’s Alzheimer’s initiative, that are getting large support at the moment). On a more micro-scale, the political frame is necessary to identify the agenda of major stakeholders in informing the U-Team’s negotiation posture towards those entities.

The human resource frame, which focuses on relationships and organizational needs, might enable the U-Team to strengthen its base of support within Walker Methodist and academic departments. For example, the Team might think about ways of more systematically engaging Walker leadership and staff in its teaching and clinical activities. It could also involve academic department heads and the Academic Health Center in articulating desired student competencies related to completing a rotation with the U-Team. Better integration and communication in this frame could lead to Walker seeing the U-Team more as an essential part of the organization (or “family”), rather than a separate unit that just happens to use the facility for its teaching and clinical activities. It could also foster more active support from university departments.

A useful concept in the human resource framework is the “emotional bank account,” which posits that individuals “debit” or “withdrawn” from the emotional bank accounts they have with another person through each interaction. Through frequent positive interactions with key stakeholders, the U-Team can maximize its emotional leverage with those individuals when
important decisions are made. The political and human resource frames need to be used when negotiations are underway with important players.

Finally, the symbolic frame, which helps give meaning and inspiration, could be better utilized to tell the U-Team’s story. Here, the U-Team would draw on powerful and meaningful examples of its impact to elicit buy-in from stakeholders such as students, patients, families and the general public. For example, what story can be told about the U-Team’s contribution to preparing the state’s health professionals to meet the needs of the rapidly aging population? How does the Team positively impact student and patient outcomes? Is there an inspirational patient or student story that could be shared? By applying these various frames, the U-Team is better able to develop concrete strategies to positively influence decisions concerning whether continued support will be given to the U-Team. Engaging others within the political and symbolic frames could provide an important means for overcoming the relative isolation and vulnerability currently experienced.
Research Methodology: Assessment of the U-Team’s Critical Success Factors

The SWOC and Stakeholder Analyses

A SWOC analysis identifies an organization’s strengths, weaknesses, opportunities and challenges. It includes an assessment of the internal environment (strengths and weaknesses) and an assessment of the external environment (opportunities and challenges). Such process lays out critical factors from the external environment and identifies how such challenges and opportunities may be dealt with through maximizing internal strengths and mitigating weaknesses, which is conducive towards deriving concrete strategies for multiple scenarios.

A stakeholder analysis identifies all stakeholders that are affected by—and influence—the U-Team. The power verses interest grid is used for this purpose. This grid places stakeholders on a two-by-two matrix where the dimensions represent a specific stakeholder’s interest in the organization, as well as the stakeholder’s power to affect the organization’s future. There are four categories of stakeholders: Players, who have both high interest and significant power; Subjects, who have high interest but little power; Context Setters, who have power but little interest; and Crowd, who are stakeholders with little interest or power.

The value of this grid comes from identifying those stakeholders who must be taken into account in dealing with the issues facing the organization (i.e. players) as well as those whose buy-in should be sought and brought in to the “players” category (i.e. context setters). The grid also highlights coalitions to be encouraged (or discouraged) as well as how each actor influences each other.

The combination of the SWOC and stakeholder analyses can help identify an organization’s critical success factors (Johnson and Scholes, 2002). These are the things the
organization must do, the criteria it must meet, or the performance indicators it must do well against in order to survive and prosper. The two analytical methods also clarify an organization’s core distinctive competencies, or the capabilities/set of actions/strategies that help the organization perform well on its key success factors better than alternative organizations that provide the same function. For example, a distinctive core competency may be means by which the organization maintains a strong reputation and trust from its key stakeholders and/or the uniqueness and quality of its products and services.

The Logic Model

A logic model specifies how a program is expected to work and achieve based on an articulated set of assumptions or related theories. The logic model used for our purposes has five components: Needs (the need each activity fulfills), Program Activities (what is being done and how), Outputs (how the scope of the activities is quantified), Immediate Outcomes and Indicators of Change (what will change in the near future, such as knowledge, attitudes, skills, aspirations), Longer Term Outcomes and Indicators of Change (what will ultimately be different through this program in terms of changed behavior and status of participants). Creating a logic model has many benefits, including that it builds an understanding of the program at hand; it aids in monitoring progress; it serves as an evaluation framework; it helps to reveal assumptions; and it promotes communications (especially to important stakeholders that may not know about the program).
Informational Interviews

We interviewed a number of individuals in the course of completing this project, covering most of the key players that influence the future of the U-Team (See Appendix B). The method employed was the qualitative research interview based on standardized, open-ended questions. The emphasis was on gaining crucial insights on not just facts, but also on the meaning behind those facts (i.e., how key stakeholders understood the reality surrounding the U-Team). As such, the content of our standardized questions changed over the semester as our understanding of our client’s issues evolved, and were adjusted in order to get at the underlying considerations of key stakeholders as they negotiate the existence of the U-Team. While the specific content from these interviews are kept confidential, the invaluable feedback we received has informed all aspects of our analysis and recommendations.
Results

Stakeholder Analysis

To better understand the nature of each stakeholder involved with the U-Team, we worked with the five primary team members (McCarthy, Osterbauer, Scheiner, Shuman, Simonson) to create a Power versus Interest Grid (see Appendix C). This grid categorizes stakeholders as Players, Context Setters, Subjects, and Crowd depending on their relative level of power to affect change regarding an issue and interest in doing so (Crosby & Bryson, 2005). This exercise helped identify stakeholders’ positions regarding the activities of the U-Team and revealed changes in interest or power that some groups must undertake in order to achieve the U-Team’s desired outcome.

Players

The U-Team’s work both depends on—and impacts—many “players,” stakeholders with high power and high interest. First, the University’s Academic Health Center, which considers interprofessional education one of its “values and strengths” (AHC, 2006) has a high interest in supporting innovative interprofessional training programs, such as the U-Team’s. The U-Team is one of the University’s few interprofessional clinical training programs—and is the oldest. Until fairly recently, the AHC provided significant financial support to the U-Team through the routing of undesignated Medical Education and Research Costs (MERC) funds received by the University to the program. Unfortunately, MERC funding, which had been obtained from the state, dried up in 2011. In addition, Dr. Frank Cerra, former head of the Academic Health Center and strong advocate for the U-Team’s program, retired his position in 2010. With Dr. Cerra’s departure, the U-Team lost its central University champion, one who had served as a focal point
for strategic communication among the U-Team’s five sponsoring colleges (at the time: Center on Aging, Dental School, Medical School, College of Nursing, and College of Pharmacy).

Second, the colleges currently providing support for U-Team faculty and staff time (Center on Aging, Dental School, Medical School, College of Pharmacy and Northwestern Health Sciences Chiropractic School) benefit from the training the U-Team provides to students. This group of stakeholders has an interest in trainee outcomes, such as numbers of students educated each year, student satisfaction, and the training’s impact on students’ capacities to provide competent care to geriatric patients, as well as to function competently within interprofessional settings. Aside from the educational component, the schools may also view the U-Team as a potential setting for conducting research with a unique demographic, although this research component would need significant focus to be developed.

Another important player is Walker Methodist Health Center, the clinical site of the U-Team. Currently Walker provides primarily in-kind support to the U-Team program, including offices, clinic space, facilities support and utilities, although it has also provided a one-time, good will contribution to the Medical School. In the case of the dental clinic, Walker also provides administrative support.

The benefits that Walker receives from the U-Team are multi-layered. Tangible benefits include the direct clinical services that each of the U-Team’s practitioners provide to Walker clients, which results in better health outcomes such as reduced re-hospitalization rates, more efficient medication management, and improved dental health. Some intangible (as of yet unmeasured) benefits Walker may receive from the U-Team’s presence include the heightened reputation brought to the facility through partnering with the University of Minnesota to provide
cutting edge, effective care to its patients, as well as having educational materials developed with Walker as their main site; the benefit of having an in-house dental clinic; the training activities that the U-Team provides to Walker’s nursing and other staff; and the potential to positively impact relationships with large area health organizations such as Fairview, Park Nicollet, Allina and others. Finally, by having University of Minnesota graduates work at Walker during training, the Center is in effect advertising to these future practitioners their facility, either for direct recruitment or for future referrals from these students.

As is to be expected, the directions of influence between players connected to the U-Team are very complex, with multiple two-directional arrows connecting almost all of them. An interesting feature of the relationship between players is that in many ways they are a closed network, meaning that the players have limited interaction with outside stakeholders who are not players themselves. This has the potential to be problematic especially when there is not much interaction between the players and the context setters, as frequently buy-in from the context setters is necessary to sustain an organization.

The reality that there are complex directions of influence between players does not necessarily mean that they are under constant communication, however. To the contrary, our interviews reveal that there is a distinct lack of cohesive communication between key decision-makers, particularly where everyone is brought to the table to engage in simultaneous dialogue. Another counterintuitive insight of the stakeholder analysis is that the U-Team functions more like a subject than a player. Lacking mechanisms to generate strategic advocacy plans, the U-Team exerts limited influence on key players (AHC, University department heads, Walker) when important decisions are made.


**Context Setters**

Context setters are actors with a high amount of financial, political or agenda setting power, but who have relatively low direct interest in the activities of the U-Team. It is crucial that the U-Team is aware of the agenda and interests of these actors, as frequently their support is necessary for the continued existence of the team. As such, efforts should be made to heighten the interest of these resource-rich actors in the U-Team’s activities, in hopes of leading them to play a more active role in the sustenance of the program.

The most powerful yet least interested context setter identified by the U-Team falls under the category “legislators and state funding administrators.” These political officials are influenced by interest groups that cater to the aging population, and in turn influence how insurance providers do business. They could also be influential in supporting funding initiatives to support Walker and the U-Team through state-level initiatives.

A formerly critical context setter for the U-Team until two years ago was Centers for Medicare & Medicaid Services (CMS), which provided financial support via the MERC program. It was this funding that launched the U-Team in 2003 and continued to sustain the program until 2010. Due to changes in regulatory language that limits the scope of the recipients, CMS funding is no longer available to the U-Team (in fact, the CMS funding that the U-Team received for 2009-2010 were drawn from the discretionary fund of the Academic Health Center).

Insurance providers such as U-Care are also context setters for the activities of the U-Team. While as of now they do not contribute directly to the operation of the U-Team, they have an interest in decreasing the overall cost of care to their insurance recipients, which makes them a potential partner. The same can be said of the hospital systems such as Allina, Fairview, and
Hennepin County Medical Center (HCMC). These systems all have an interest in providing quality care through lower costs, which the U-Team’s model promotes. Also, in light of the Affordable Care Act there is a potential for the establishment of Accountable Care Organizations that incentivizes the type of care that the U-Team provides, of which the above mentioned hospital systems would be part.

*Subjects and the Crowd*

In pushing for the shift of context setters to players (or at least for the devotion of resources to the U-Team by the context setters) and for players to view the U-Team in a more favorable light, it is important to identify who the subjects and crowds are. While these actors may not have much power to influence the U-Team’s viability directly, they have the potential to exert pressure on the actors who do. Here, subjects refer to actors that have low power to directly impact the U-Team but have a high interest in its activities.

Among the most important subjects are the students who receive training from the U-Team. They have a direct stake in the program’s quality and capacity to continue offering quality interprofessional geriatric training. Relatedly, future employers are likely to care about the quality of geriatric training these students receive. Given that one in five patients in a general health care clinic are currently over the age of 65, the vast majority of health professionals need to be competent providing health care to older adults. Particularly for those students who plan to specialize in providing care to geriatric patients, this program is vitally important.

The patients who are cared for by the U-team have a direct stake in the quality of care they will receive, making them subjects as well. The families and loved ones of these patients also likely care deeply about the quality of care received. In addition, older adults throughout the
state have an interest in ensuring a robust pool of competent and qualified geriatric health care professionals will be available to provide their care in future years. These direct beneficiaries of the U-Team’s services also bring in a host of organizations that cater to these populations. Professional organizations such as the American Geriatrics Society (AGS) and the Minnesota Medical Directors’ Association (MMDA) have a high interest in the U-Team’s work, as do other organizations such as Metropolitan Area Agency on Aging (MAAA), Aging Services of Minnesota, the Minnesota Gerontological Society, and others.

Actors in the crowd, while having low power and low interest, nevertheless have the potential to influence players and context-setters through their existing linkages. As a whole, the aging population (and the interest groups and advocacy organizations that promote their general welfare) has little knowledge of the service that the U-Team is providing. Similarly, other academic units that have the potential of benefiting from participating in the program likely do not know about the U-Team’s work.

The pattern of influence identified by the U-Team yields some interesting patterns. First, it appears that the direction of influence generally flows from actors in the crowd to actors who are context setters. This seems to be due to the fact that the context setters are frequently public (or public-minded) actors that are sensitive to popular support. For example, state legislatures and CMS are sensitive to the pressures from interest groups that represent senior citizens. On the other hand, there seems to be very limited influence exerted by the subjects on players, which indicates that there may be an issue in communication between the two groups.
SWOC Analysis

External Environment

The opportunities identified by the U-Team fall into five categories: funding, education, clinical services, public relations, and “the silver tsunami.” Specifically, the potential of grant funding for the U-Team’s interprofessional geriatric care model was cited as being an important funding opportunity, which is supplemented by the demonstrated cost-effectiveness of improved poly-pharmacy management. The unique and important educational training opportunities that the U-Team can potentially provide to the University of Minnesota and chiropractic students as well as Walker staff is also cited as an important opportunity. The increasing need in the community for the U-Team’s specialized service was also noted repeatedly as an important opportunity, which is reflected in the “silver tsunami” discourse. The U-Team’s work in Walker’s delirium unit was highlighted as one potentially important opportunity in these regards.

The challenges identified by the U-Team fall into four categories: lack of ownership and business model, ageism, and lack of legislative funding. Specifically, the lack of recognition of the full value brought by the U-Team has resulted in a decreased will on the part of the U-Team’s partners to support its programs. This is due to the lack of administrative capacity (a weakness of the U-Team), but also the lack of a business plan. Such a lack of a business model has led the U-Team to have difficulty in explaining the value it brings to the AHC and the four University departments, as well as to Walker. Another significant external challenge is the slow progress of health care reform, which resulted in decreased state revenue that would be able to support the U-Team (See Appendix D for the SWOC).
Internal Environment

In dealing with the external environment, the U-Team has cited distinctive strengths and weaknesses. As for the strengths, the broad categories are clinical expertise, the competitive draw to students, and educational effectiveness, or in other words, programmatic competencies. Specifically, clinical care outcomes of the U-Team are demonstrated to be very good (including decreased overall costs), which is acknowledged to be the future of care provision in the field of geriatrics. The educational value brought by the interprofessional training of the U-Team is exceptional, including unique training of faculty, students and Walker staff under the interprofessional model as applied to vulnerable patients (e.g. patients in the dementia unit), as well as providing a potentially fruitful area of research to the faculty.

There are some objective illustrations of such clinical efficacy of the U-Team. In a survey conducted with 57 students who participated in the Walker program between 2004 and 2005, students reported an increased interest in providing geriatric care as a result of the rotation. Plus, in an evaluation of the U-Team’s interprofessional geriatric practice on Walker’s Transitional Care Unit, patients cared for by the U-Team were shown to have considerably shorter lengths of stay, enabling them to return to their communities more quickly (Blewett et al., 2004). These patients were also shown to have lower total charges, resulting in considerable savings for respective health insurance providers.

The weaknesses of the U-Team come from non-programmatic competencies. The main weakness cited is the lack of commitment from key stakeholders such as the AHC and respective university departments. While there are many reasons for this lack of support, one reason is the lack of a systemic documentation of the above mentioned strengths. Such lack of documentation
has negatively impacted the U-Team’s funding efforts that have focused largely on soliciting departmental support towards the program. An unfortunate result of this situation was the withdrawal of the School of Nursing from the U-Team in 2010, which in turn was a blow to the U-Team’s programmatic competency as well. As highlighted in the Blewett report (2004), “the intense involvement of the nurse practitioner in the day-to-day activity of the TCU staff was frequently identified as an important contributor to the success of this project” (8).

A more fundamental weakness, however, is that the current incentive structure does not reward or compensate the U-Team or Walker for cost-savings associated with improved clinical outcomes or shorter TCU stays. This makes it very difficult for the U-Team to “pay for itself” through traditional fee-for-service arrangements. Without a financially viable business model and documented evaluations of solid educational outcomes, the U-Team is dependent on contributions from respective departments that believe in the principle of interprofessional geriatric education despite lack of robust documented evidence. Aggravating all of the above is the fact that the U-Team could not invest in administrative capacity that would enable it to put more thought and energy into strategic issues and its programmatic activities.

**Logic Model**

It is crucial to point out that the logic model of the U-Team (as reproduced in Appendix E) is a preliminary version, based on time-limited feedback from the U-Team members. Despite this restriction, the current model yielded some key insights, both about activities that the team engages in, but just as importantly, about activities in which it does not currently engage. We will deal with each in turn.
First, there are only two components to the U-Team’s work: educational and clinical. In its face, the U-Team’s activities are logically connected with relevant outputs and outcomes that lead to improved student education and patient care, in a manner that promotes the benefits of interprofessional geriatric training. Upon closer examination, however, it becomes apparent that there is relatively little systematic evaluation being conducted to gauge the progress made in each of these outcomes. A comprehensive evaluation plan that identifies and measures appropriate outputs and outcomes would bridge this gap. Another activity missing from the logic model is outreach and communication related to the program. The addition of activities in this area could be a necessary condition for the U-Team to achieve some of its desired long-term outcomes such as having “geriatrics seen as viable profession” and “practice changes are implemented more broadly.”

**Summary and Analysis of Results**

The SWOC and stakeholder analyses, logic model exercise, and interviews yielded insights regarding the U-Team that can be classified under two broad themes. The first are insights that had to do with internal organizational capacity of the U-Team. The second batch of insights had to do with how the U-Team communicates with outside stakeholders.

**Internal Organizational Capacity**

First, it is important to note that the U-Team seems to be doing a remarkable job despite its circumstance. Specifically, the U-Team is a well-functioning unit that is creating positive educational and clinical outcomes. The “Interprofessional Education for Collaborative Patient-centered Practice” (IECPP) model proves useful in demonstrating how this happens.
Under the Educational System wheel, the Teaching (Micro) factors such as faculty development and promoting a good learning context are being done well, mostly because this is under the purview of motivated U-Team members. For example, weekly rounds among the four departments as well as constant communication between the respective clinicians throughout the week seem to be maximizing student learning by exposing them to a multi-dimensional approach of how to treat difficult patients.

However, such results are dampened by weaknesses in Institutional (Meso) factors such as leadership/resources and administrative processes. For example, the lack of dedicated administrative or operational support has been noted as resulting in a decrease in quantity and quality of initiatives other than weekly rounds that can engage with the larger student body. The lack of a central “go-to” person has likely negatively impacted the clinical performance aspect of the U-Team as well, considering the strong contribution such a person has made in previous years of the team. Lack of opportunities to engage in strategic thinking about pedagogical methods as well as lack of higher level leadership has prevented the U-Team and University departments from coming up with more creative arrangements to expand the U-Team’s potential to educate a larger student population. Most critically, the lack of will to invest resources from the U-Team’s sponsors (both University departments and Walker) is putting the U-Team’s operations at risk.

Under the Professional System wheel, the U-Team is relatively strong in its Interactional (Micro) factors, namely the degree of its sense of belonging, as well as the sharing of goals and vision. Most of the U-Team’s members have been working together for some time, and all have a strong commitment to the model in general. However, such informal interactional factors are
vulnerable to changes in the external environment (like the one the U-Team is facing now) if it is not supported by Organizational (Meso) factors. For example, the lack of structural devises to ensure common understanding of goals and missions (i.e. a strategic plan) increases the risk that the U-Team would not have a clear set of guidelines to turn to when a significant decision involving the organization’s future has to be made. Also, the lack of a clear governance methodology and structure prevents the U-Team from engaging in strategic activities that would benefit the U-Team’s clinical effectiveness in the long run (e.g. advocacy for more funding, etc.).

A fundamental Organizational (Meso) factor that is lacking with the U-Team is a viable business model, at least with regards to its clinical activities. In essence, the financial benefits of improved clinical outcomes (e.g. decreased re-hospitalization rates, decreased average time under the Transitional Care Unit) are not being reflected positively in its partner organization’s bottom line under the current incentive structure. Such a misaligned incentive structure has negatively impacted the U-Team’s ability to argue for its financial solvency.

In summary, it seems that a few basic measures need to be taken to maximize on the U-Team’s strengths and mitigate its weaknesses with regards to its internal organizational capacity. First, regular communication about operational and strategic matters needs to be organized between U-Team members. This is a structural device that would generate necessary leadership and strategies to tackle all other challenges facing the U-Team. Second, it would seem best to have a point person to coordinate the daily activities of the U-Team and engage in strategic thinking as well. If dedicated programmatic support is not currently available, the U-Team members could rotate this responsibility on a monthly basis. Third, a serious effort to document and measure the impact that the U-Team is making on both its students and patients would go a
long way to provide both internal benchmarks as well as external talking points. Fourth, the U-Team needs to engage in strategic work related with how correct for the currently misaligned incentive structure of the U-Team’s clinical services.

**External Communication Capacity**

A key insight from looking at stakeholders is the fact that the U-Team and major players involved are not engaged in direct strategic communication with their subjects, crowds and potential context setters (read: financial and institutional sponsors). This has resulted in the illusion that the resource pie is effectively fixed, with only Walker and the University’s departments available to fund the U-Team’s efforts (with the exception of MERC funding). In other words, when talking of “value-added by the U-Team” the implied definition of the term is the amount of money that the U-Team brings to the table. This does not have to be the case. Through active engagement with external stakeholders, the U-Team can effectively increase the saliency of other values brought by its services: increased educational experience of students, increased quality of life of patients, increased cost-savings to society as a whole (and ACOs/insurance companies in particular).

When looking at the direction of influence among stakeholders classified as subjects and crowds, potential advocacy strategies become apparent. The IECPP model offers a good frame of reference. First, the Educational System of the U-Team’s program can increase in effectiveness by harnessing the power of subjects, namely students. Specifically, creating systems to promote to and incorporate feedback from students will greatly enhance the U-Team’s effectiveness in its educational mission while enhancing its standing with the University departments. This would include comprehensive evaluation schemes that assess the degree of learning by the students as
well as innovative ways to advertise and expand opportunities in which students can be involved with the U-Team’s activities.

Implementing systems that engages with and incorporates feedback from patients (the other subject from the stakeholder analysis) would be invaluable to the U-Team’s Professional System (i.e. clinical effectiveness) as well. Objective indicators of patient satisfaction aside, eliciting compelling narratives from them can go a long way towards an effective advocacy campaign to raise public support of the U-Team’s activities, which in turn may function as the U-Team’s political leverage in dealing with its sponsors. This insight is also applicable to the aging population in general, whose interests are frequently represented by special interest groups. A strategic outreach effort to this group has the potential to be a very powerful political leverage that can change the entire incentive structure surrounding the U-Team.
Recommendations: Scenarios of How to Satisfy Necessary Conditions

Based on our assessment of the challenges and opportunities facing the U-Team as outlined previously, we have considered several options for the U-Team to consider. As noted above, these recommendations focus on maximizing the internal potential of the U-team to positively impact its sustainability while recognizing that the team has little if any control, at this point, over the decisions and actions of Walker and participating academic departments. Over time the U-Team should work to more actively engage these important stakeholders.

In the first of two options we envision, the U-Team would continue to teach and practice at the Walker site. A number of advantages are associated with this option, including already established relationships and familiarity with staff and systems, existing infrastructure, established dental clinic, Transitional Care Unit and reputation of Walker Methodist. Disadvantages associated with this option include the lack of support from the University’s Academic Health Center and tenuous history with several other key stakeholders, limited support from Walker due to a business model that does not adequately the value of the U-Team’s contributions, and limited administrative or operational support provided to the Team.

In the second option, the U-Team decides to leave Walker and searches for a new partnering organization, where teaching and clinical activities could be continued and perhaps expanded. This second option assumes close collaboration with participating academic departments—and ideally the University’s Academic Health Center—to determine possible sites and establish necessary relationships and contractual agreements. Potential advantages to the U-Team’s leaving Walker include an opportunity to get a “fresh start,” redefine the program’s
mission and methods of achieving core activities, and build a culture with a new partner of open and consistent communication, as well as a shared vision.

Other advantages to this option include possibilities of finding a partner who could offer the U-Team capacities it currently lacks: additional operational and administrative support, better teaching space, an infrastructure that can build on the U-Team’s innovative model to apply for research and other funding to build a robust program focused on best practices of geriatric care. Finally, leaving Walker could provide the U-Team with opportunities to bring renewed support from the Academic Health Center, reengage the School Nursing and attract additional students and patients. Possible disadvantage with leaving Walker include the uncertainty of risks involved (start-up costs, etc.), transitional costs (navigating new relationships, learning new systems, moving, etc.) disrupting the team’s current educational and clinical environment, including the transitional care unit (TCU) and leaving the dental clinic space currently at Walker.

In either scenario, we recommend the U-Team establish mechanisms for building ongoing strategic and operational dialogue into its work by engaging in the following activities:

**Step 1: Establish mechanisms for ongoing strategic and operational dialogue**

**Recommendations:**

- **Regular meetings of the U-Team**

  We recommend that the U-Team use weekly or biweekly to discuss operational and strategic issues, publicity and broader outreach work, challenges faced, curriculum, etc. Create an agenda and rotate facilitators to keep the meetings focused and productive. Consider inviting others who can help the U-Team as appropriate (Linda
Berglin, etc.). An easy way to incorporate these “business” meetings into your regular functioning would be to schedule them before your weekly grand rounds – take turns bringing bagels and have fun!

- **Regular meetings between the U-Team and partner site**
  Quarterly meetings between the team and Walker administration (or other site) would help keep the U-Team’s work “on the radar” of the organization’s leadership, help the site think about how best to integrate the U-Team’s teaching and clinical work into its own strategic plan, and facilitate ongoing, open communication. Again, have an agenda prepared in advance, bring food as appropriate, and give your partner the opportunity to get to know you as a team – not just as individual clinicians!

- **Regular meetings between U-Team, department heads, and Walker leadership**
  Quarterly or biannual meetings between the key program “players,” including U-Team members, academic department heads, and Walker leadership will help keep communication channels open, build shared commitment and vision, and help overcome the “silo effect,” related to distinct departmental budgets allocating funds to support U-Team faculty, etc.
Step 2: Develop shared agreement among U-Team members, Walker leadership and participating departments (MOA)

Recommendations:

- **Collaborate to redefine or affirm mission**
  
  Develop a simple memorandum of agreement (MOA) between participating departments, Walker, and the U-Team. What is the team’s mission? What are its goals? Are the outcomes delineated in the logic model those desired by key stakeholders? Should anything be tweaked or changed? How will each department—and Walker—contribute to sustaining the program? Bringing key stakeholders together to define mission and goals will help create buy-in and much needed support.

- **Engage stakeholders to refine curriculum**
  
  What specific geriatric and interprofessional competencies do participating departments want their students to achieve by completing training with the U-Team? Collaborate with participating academic units to develop curricular materials documenting skills and knowledge students who train with the U-Team should receive. Use this information to help build the program through existing departmental sponsors and potential other collaborating units.

- **Clearly define obligations and responsibilities**
  
  Spell out organizational commitments. What does each unit commit to contribute? What are its expectations? This recommendation is aimed at concretizing the shared mission
and vision of key stakeholders and minimizing the uncertainty experienced by the U-Team, as well as creating more shared accountability.

- **Establish simple evaluation plan**
  Determine what initial measures the U-Team and participating units are interested in capturing. In addition to tracking numbers of students trained and patients seen, for example, what do students think about their training experiences at Walker? Do they have suggestions for improvement? What do patients say? Not only are numbers important to capturing the U-Team’s work, but the stories of individuals impacted by the program would help provide valuable information as well.

**Step 3: Develop outreach strategy**

**Recommendations:**

- **Devise outreach strategy**
  We recommend developing a strategic outreach, advocacy and visibility plan for the U-Team to assist the program with “telling its story.” Engage outside program supporters in this work! Consider organizing a broad-based stakeholder meeting to discuss outreach strategies to get ideas and enlist the support of volunteers. The community is full of individuals who would be enthused about the opportunity to help support the U-Team with this work. Don’t be afraid to ask for help!
Aspirational steps

Finally, once the previously outlined steps are well underway, the U-Team may consider developing a more comprehensive strategic plan, including evaluation activities, to measure its impact and provide information to inform program improvement and expansion. Additionally, it would be ideal if the U-Team had part-time administrative and/or higher-level operational support available to help coordinate meetings and student activities, collect data and help with other programmatic and communication needs.

Finally, we recommend an additional step should the U-Team decide to leave the Walker site and pursue other partners.

Step 4: Ensure compatibility between U-Team and partner missions

Should the U-Team determine that leaving the Walker site is in its best long-term interests, we recommend the group engage in a dialogue about desired attributes of an ideal partner. Ideally, this discussion would take place on several levels: first within the U-Team and next with participating departments and the Academic Health Center. These discussions would be an opportunity for the U-Team to envision the type of future it wants to see realized—and to figure out how best to move forward with these goals.

Conclusion

With scant resources to train geriatric clinicians for the future, the nation—and Minnesota—is at a critical juncture. Despite inadequate resources, the U-Team should be very proud of its contributions over the past decade on this defining issue. The group can be delighted by the cadre of students they have trained over the years, individuals who will care for our
parents, grandparents and selves as we age. The U-Team can also point to their successes in proven positive clinical outcomes, including reduced re-hospitalizations, improved medication management, and exceptional dental care. Finally, the U-Team should be held up as an example of a successful interprofessional model, particularly as others look for ways to implement similar models in other settings.

With so much to build on, the U-Team should look to the future and create a strong communicative environment and develop a robust MOA with all relevant stakeholders. By taking a more active role communicating with stakeholders the U-Team will be able to redefine their power and move from the “subject” to “player” position as defined in the stakeholder analysis. As a result of conducting meetings, engagement and outreach to nontraditional stakeholders the U-Team can harness control of the program. Our group strongly believes if the U-Team incorporates our recommendations as defined in the previous section, a sustained interprofessional program that prepares Minnesota clinicians for the oncoming “silver tsunami” will follow.
Bibliography


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# Overview of the Education and Training of Professionals in Geriatrics

<table>
<thead>
<tr>
<th></th>
<th>Nurses</th>
<th>Pharmacists</th>
<th>Physical Therapists*</th>
<th>Physician Assistants</th>
<th>Physicians</th>
<th>Psychologists</th>
<th>Social Workers</th>
</tr>
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<tbody>
<tr>
<td><strong>Total jobs held (2006)</strong></td>
<td>RNs: 2.5 million</td>
<td>243,000</td>
<td>175,000</td>
<td>66,000</td>
<td>633,000</td>
<td>182,000</td>
<td>595,000</td>
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<tr>
<td><strong>Geriatric specialization or certification</strong></td>
<td>Less than 1% of RNs and about 2.6% of APRNs certified</td>
<td>1,297 certified (less than 1%)</td>
<td>798</td>
<td>Less than 1% specialize</td>
<td>7,590 certified in geriatric medicine; 1,657 certified in geriatric psychiatry</td>
<td>Approximately 3% devote majority of practice to older adults</td>
<td>About 4% of social workers specialize</td>
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<td><strong>Academic leadership</strong></td>
<td>76% of baccalaureate programs have at least one full-time “expert,” 29% have a certified faculty member</td>
<td>43% have two full-time faculty; most rely on part-time faculty</td>
<td>27% of program directors surveyed had some form of geriatric training</td>
<td>Less than 1% of faculty specialize; all programs have an identifiable leader in geriatrics</td>
<td>Data not available</td>
<td>40% of schools have no faculty knowledgeable in aging</td>
<td></td>
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<td><strong>Exposure to geriatrics in schools</strong></td>
<td>1/3 of baccalaureate programs require exposure; 94% of fundamental courses integrate geriatric content</td>
<td>43% have a discrete course; all schools provide opportunity for advanced training in geriatrics or long-term care</td>
<td>Accreditation requires geriatric coursework and exposure.</td>
<td>Accreditation requires geriatric exposure, including clinical experience in long-term care</td>
<td>98% of schools require some form of exposure</td>
<td>Approximately 30% of graduate training programs offer coursework in aging</td>
<td>80% of BSW students have no coursework in aging</td>
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<td><strong>Advanced geriatric training programs</strong></td>
<td>Less than 100 master’s and postmaster’s programs; five programs in geropsychiatric nursing</td>
<td>10 residency programs; one fellowship program</td>
<td>3 Geriatric Approved Clinical Residences</td>
<td>None</td>
<td>Medicine: 139 fellowship programs (469 1st-year positions); Psychiatry: 58 fellowship programs (142 1st-year positions)</td>
<td>13 graduate programs with substantive training opportunities in geropsychology; 97 graduate internships have a “major rotation” in geropsychology</td>
<td>29% of MSW programs offer aging certificate, specialization, or concentration; DSW: unknown</td>
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<td><strong>Number of Advanced geriatric trainees</strong></td>
<td>Approximately 300 geriatric APRNs produced annually</td>
<td>13 resident slots; one fellowship slot</td>
<td>Different number of slots in each of the 3 residencies</td>
<td>Not Applicable</td>
<td>Medicine: 253 in 1st year; 34 in 2nd year; Psychiatry: 726</td>
<td>Approximately 40 postdoctoral geropsychology fellowships annually</td>
<td>Unknown</td>
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<td><strong>Explicit testing on non-geriatric board certification exams?</strong></td>
<td>Yes</td>
<td>No general certification; national licensure exam organized by approaches23</td>
<td>Yes</td>
<td>Internal Medicine: 10% of exam; Family Medicine: optional module; Psychiatry: yes</td>
<td>Examination for Professional Practice in Psychology (EPPP) includes items with geropsychology content</td>
<td>No general certification; national licensure exam organized by approaches</td>
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<td><strong>Average Salary</strong></td>
<td>LPN: $40,110 (average)</td>
<td>$104,260 (average)</td>
<td>$60,000 (average starting)</td>
<td>$81,610 (average)</td>
<td>$161,888 (average geriatrician)</td>
<td>$58,000 (average starting)</td>
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<td>BA: $30,375</td>
<td>$101,892</td>
<td>$63,847</td>
<td>$60,000</td>
<td>$141,751 (medical schools)</td>
<td>$85,000</td>
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* Data not from these sources

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Adapted from the IOM Report, Retaining an Aging America: Building the Health Care Workforce; Pg 130-131 [http://www.nap.edu/catalog/12089.html](http://www.nap.edu/catalog/12089.html) and the American Geriatrics Society’s Geriatrics Workforce Policy Studies Center [http://www.adgapstudy.uc.edu/index.cfm](http://www.adgapstudy.uc.edu/index.cfm)
APPENDIX B: Interviews completed

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Stephen Shuman, DDS
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### APPENDIX D: SWOC Strategy Analysis Worksheet for U-Team

<table>
<thead>
<tr>
<th>Internal</th>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
</table>
|          | • Better clinical outcomes  
          | • Right place right time re: clinical care model | • Does not generate funding/revenues  
          |                                      | • No academic nursing involvement  
          |                                      | • Divided roles, demanding |

<table>
<thead>
<tr>
<th>External</th>
<th>Opportunities</th>
<th>S-O Strategies</th>
<th>W-O Strategies</th>
</tr>
</thead>
</table>
|          | • Possible grant funding for the teaching and care models; possible research opportunities  
          | • Unique, important and needed training for students  
          | • Cost savings of pharmaceutical care | Being in the “right place at the right time,” combined with positive clinical outcomes creates unique opportunities to obtain external funding to support teaching, clinical and/or research initiatives.  
          |                                      | Being ahead of the curve in IP and geriatrics education creates opportunities to expand. | Determine a model to capitalize on the positive economic impacts of poly-pharmacy and improved clinical outcomes demonstrated by U-Team. |

<table>
<thead>
<tr>
<th>Challenges</th>
<th>S-C Strategies</th>
<th>W-C Strategies</th>
</tr>
</thead>
</table>
| • Ageism  
          | • Resources (time, funding) for U-Team promotion, operationalization, etc.  
          | • AHC/U of M School support | Better capitalize on U-Team strengths to garner stakeholder support and assistance with ongoing operational, visibility and sustainability issues.  
          |                                      | Reengage UMN School of Nursing and/or explore opportunities to form partnerships with non–University of Minnesota affiliated nursing schools. |
## APPENDIX E: U-Team Logic Model

<table>
<thead>
<tr>
<th>Need</th>
<th>Activities</th>
<th>Outputs</th>
<th>Intermediate Outcomes</th>
<th>Long-term Outcomes</th>
<th>Vision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Education and training to prepare students and practicing health professionals to care for older adults (geriatrics training).</td>
<td>- Develop curriculum and educational materials.</td>
<td>- Materials available and disseminated.</td>
<td>- Student knowledge and attitudes improve (geriatrics and IP).</td>
<td>- Geriatrics seen as viable profession.</td>
<td>Ageism reduced.</td>
</tr>
<tr>
<td></td>
<td>- Provide didactic instruction (geriatrics and IP) to students.</td>
<td>- Students trained by discipline (#)/length and breadth of training.</td>
<td>- Students meet educational requirements.</td>
<td>- Trained, competent professionals exist to provide care for older adults.</td>
<td>Older adults receive better overall care and experience improved health outcomes and quality of life.</td>
</tr>
<tr>
<td></td>
<td>- Lead and participate in IPE geriatric rounds.</td>
<td>- Staff trained (#).</td>
<td>- Staff demonstrates improved knowledge.</td>
<td>- Walker staff is more satisfied and retention improves.</td>
<td>System delivers more cost efficient care to older adults.</td>
</tr>
<tr>
<td></td>
<td>- Supervise student clinical rotations.</td>
<td></td>
<td>- Walker is solidified as IPE site.</td>
<td>- Staff provides better care to Walker residents/patients.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Teach Walker staff.</td>
<td></td>
<td>- Academic programs receive accreditation.</td>
<td>- Program actively supported by participating academic programs and becomes financially sustainable.</td>
<td></td>
</tr>
<tr>
<td>Health services for older adults with complex health needs to improve health and QoL (Walker patients and residents).</td>
<td>- Provide clinical care.</td>
<td>- Number of patients/residents seen.</td>
<td>- Improved patient outcomes (reduced unnecessary meds, hospitalizations, etc.)</td>
<td>- IP education and practice become standard (efficacy of model established).</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Provide IP consultations.</td>
<td>- Times consultations to colleagues provided.</td>
<td>- Costs are reduced.</td>
<td>- Care model becomes financially sustainable.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Teach Walker staff (also above).</td>
<td>- Number of staff trained.</td>
<td>- Walker viewed as a care innovator.</td>
<td>- Practice changes are implemented more broadly as a result of information gathered and shared.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Design and conduct research.</td>
<td>- Grants applied for/received.</td>
<td>- Delirium program grows.</td>
<td>- Delirium care nationwide improves.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Deliver presentations to local, regional and national audiences about best practices in care of older adults.</td>
<td>- Presentations delivered.</td>
<td>- Walker has better survey results.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Publish research results and clinical/teaching best practices.</td>
<td>- Manuscripts/articles published.</td>
<td>- Students and faculty collaborate on research projects.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Intermediate Outcomes</strong></td>
<td><strong>How will we know we're continuing to move toward long-term outcomes?</strong></td>
<td></td>
<td>- Research results disseminated.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Long-term Outcomes</strong></td>
<td><strong>What do we hope will ultimately be different for participants?</strong></td>
<td></td>
<td>- Audience knowledge improves and practice changes result.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Vision</strong></td>
<td><strong>Ageism reduced.</strong></td>
<td>Older adults receive better overall care and experience improved health outcomes and quality of life.</td>
<td>System delivers more cost efficient care to older adults.</td>
<td></td>
</tr>
</tbody>
</table>
The “Silver Tsunami”
Interdisciplinary Geriatric Care in Minnesota

The first wave of baby boomers turned 65 in 2011. Over the next two decades, Americans over the age of 65 will increase from 39 million to over 70 million. In addition, roughly one in four Minnesotans will be over the age of 65 by 2030 and the number of people over 85 will triple. The population is not only aging rapidly, but people are living longer. This “Silver Tsunami” is coming. Yet, our health care system is, in large part, unprepared to meet this challenge. The availability of health care professionals adequately trained to address the health care needs of older adults lags behind reality. In addition to the current shortage of professionals trained to meet the needs of older adults, our educational system is largely failing to train the next generation of geriatric practitioners. Inadequate geriatric training exists in medicine, nursing, pharmacy, dentistry, physical therapy and communication studies. One of the institutions taking an active role in addressing this lack of geriatric clinicians is the University of Minnesota.

The University of Minnesota’s Geriatric Inter-professional Teaching and Practice Team (U-Team) is an educational training program and clinical practice located at Walker Methodist Health Care Center (Walker Methodist), a 488-bed skilled nursing facility located in Minneapolis, MN. The university brings together several of its schools (dental, medical, pharmacy, and nursing) as well as external schools (chiropractic) to help provide U of MN students and Walker Methodist patients with an environment for students to provide interdisciplinary geriatric care, and have patients receive a more efficient and effective, health care experience.

This partnership, which began in 2003, is the sole interdisciplinary geriatric partnership.

Through the U-Team’s interprofessional education programs, roughly 100 students are immersed in the two aspects of the geriatric programs: education and clinical.
While the U-Team is leading the way in geriatric care in Minnesota, it is encountering unique internal as well as external organizational capacity deficiencies. These organizational deficiencies, that were outlined based on our analysis, are areas in which the U-Team can address to strengthen the partnership and the product to clients as well as students.

Recommendations

**Step 1: Engage in Strategic Dialogue with the U-Team**

**Step 2: Develop a Shared Agreement (MOA)**

**Scenario 1: Maintain Relationship with Walker.**
1) Negotiate Unified Contract
2) Devise comprehensive outreach strategy

**Scenario 2: Initiate New Partnership.**
1) Clearly define what players need and want in new partnership
2) Exert active role in partner recruitment