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A healthcare organization converted compliance training to bite-size learning to reduce the time workers are away from patient caregiving.

BY DARCI HALL

rolearning Meets Compliance

The healthcare industry, while dynamic and innovative when it comes to medical practices and patient care, can often lag in other areas of the business that are not its core competency. L&D is a prime example. But rather than an obstacle, L&D professionals working in healthcare should view this as an opportunity to help transform the workplace.

The first step in modernizing any industry is to understand how work gets done. That means L&D practitioners need to walk hospital hallways, visit a clinic, or volunteer at an outpatient facility to immerse themselves in the workplace.

Here's the problem: Clinicians are the most difficult healthcare population to design learning solutions and development opportunities for. As "boots on the ground," they often have limited access to technology and strict time constraints. For instance, when a nurse must spend time off the floor to participate in training, that creates an additional burden on the rest of the team, which can ultimately affect patient care.

Traditional learning modalities such as classroom-based, instructor-led training fail to meet this busy workforce's needs. But just-in-time learning can address that issue.

In addition, it's especially important to recognize that for this population, one-size learning does not fit all caregivers. Instead, L&D must design learning for various modalities (podcasts, asynchronous e-learning courses, and virtual instructor-led sessions, to name a few) to create an overall learning experience that meets every learner's individual needs and increases access to education.

Merger's impact on L&D

In 2016, Renton, Washington-based Providence Health & Services merged with St. Joseph Health System, of Irvine, California. The result was Providence, a healthcare system comprising some 120,000 caregivers who serve in 51 hospitals and 1,085 clinics and a comprehensive range of health and social services across Alaska, California, Montana, New Mexico, Oregon, Texas, and Washington.

While growing this health system was good news for patients, the merger added a level of complexity to the L&D function. For starters, many of the new hospitals and clinics already had their own learning technologies, everything from collaboration tools to learning management systems. Consequently, one of the L&D team's first efforts was to streamline the technology and develop governance around management and maintenance.

We also experienced a lot of duplication of learning assets. After the merger, we discovered we had more than 1 million pieces of content in our LMS. For example, there may be 10 training videos on how to manage patient falls. But Providence's policy and guidelines on that issue are essentially the same throughout all the locations, so the content within the videos should also be the same. In other words, we only need one video.

More troublesome, hospitals, clinics, and other service providers were managing regulatory training in different ways and on varying schedules. For state and federal requirements that were the same, we had duplicate learning options that we wanted to consolidate. We also wanted all compliance training to follow the same annual timeline.

To address those issues, the L&D team conducted ethnographic studies with each region to transform our learning offerings. We walked hallways to see what the working environment was like, and we conducted interviews to glean insights about the day-to-day work of different roles. What learning did they need? What was missing from the training they were already receiving? How and when did they access learning solutions?

We soon learned that even more complications were at play. Patient care is always evolving—whether that's due to medical treatment advancements or federal guidelines. And training to support those changes must respond quickly and hopefully not interfere with the course of daily work.

Finally, like every other industry, it became clear that our caregivers expected more consumer-grade learning. In the age of Netflix and Amazon, they wanted digital, personalized, just-in-time options and support.

Enter microlearning

Based on our findings, we began to explore digital-enabled delivery strategies. But before we could move forward, we had to consider the organization's readiness to make a change to a more progressive way of learning. Given the gravity of the content as well as state and federal compliance and regulations needs, many caregivers held the belief that learning was best deployed via instructor-led courses or lengthy e-learning programs that seemed to better support tracking requirements about knowledge, proficiency, and completion. Many did not think beyond the classroom to just-in-time learning, nor did the caregivers feel empowered to drive their own learning.

If our team was going to modernize learning at Providence, we knew we needed to succeed on our first attempt. That meant connecting a targeted pain point to some sort of training that affected the entire organization.

Through interviews, we uncovered that caregivers were dissatisfied with annual caregiver compliance training. They thought it took longer than necessary and was the same content each year. In fact, caregivers who had been with the organization for numerous years felt that repeating the training every year was unnecessary and a waste of their time.

But we also knew that we needed robust reporting for this training that would meet the compliance department's needs. And because many of the organization's regions and caregivers are contracted labor, tracking completion was especially paramount.

In the end, we settled on developing a microlearning solution for the compliance training. L&D's goals for the new learning were to reduce training time, personalize the experience, increase engagement, make the learning accessible via mobile device or PC, and measure and track proficiency.

Meanwhile, L&D's challenges revolved around how to inform all 120,000 caregivers and stakeholders about the change and how everyone would now access learning. For example, because many caregivers are contracted labor, we would not only need to inform employees, but we also would need to work with the unions to communicate the changes. Additionally, we required policy changes that allowed caregivers to use their mobile devices to access the learning, as well as provided shared PCs and access to hardware and devices, because many employees share workstations or do not have PCs available at all, such as transporter and environmental service caregivers.

Personalized design

Once we determined our outcomes and deployment challenges, the next step was to design the learning experience based on all that we knew about our caregivers, the organization, and measures of success.

Working within a development tool, we designed a solution that simplified the learning experience and enabled multiple access options. First, we used an email to invite caregivers to participate in the training program. That initial message explained that the program would ask them to answer three random questions (out of a total of 50) every few days, and then the email linked them to a website to begin. Via the email, users could also opt to participate via an app that they download to their mobile device.

If users answered questions correctly, they received immediate feedback on their proficiency and the questions were retired. Essentially, anything they already knew, they didn't have to receive any further learning on.

If they answered a question incorrectly, though, the program pushed the learner to review a one-minute microlearning asset. That could be a video, piece of text, or audio clip that we repurposed from the existing e-learning course. Our team developed at least one piece of microlearning for each question. Then the question would be recycled and asked again within four days. Learners could not predict the order of questions or when a previously incorrect question would reappear.

In addition, if learners stopped participating, they received prompts to continue with more questions. An email notification or a text message on their phone may invite them to answer a new set of questions, or a notice may offer a reminder about official deadlines for completing the entire module and achieving compliance.

The new setup reduced the amount of training time by more than two-thirds.

It's important to note that we were only redesigning the experience. The questions, for instance, were all based on compliance requirements, and the instructional elements were already in place from the existing e-learning course. Our intent was to unravel the learning and reknit it together into a new, faster, more accessible, and personalized option for caregivers.

Time to pilot

After we had fully designed the module and tested the technology among the L&D team, we next piloted the technology with two user groups. The pilots were two months in length, with 26 questions deployed to users. We chose the first pilot group to include Providence leaders from Southern California. That group had access to PCs, were nonexempt and nonunion, and were not typically patient-facing staff. Our goals for the Southern California group were to obtain leader buy-in, measure engagement, and help drive change within their teams if and when we deployed.

The second user group included clinical individual contributors in our Texas region, such as nurses, nurse managers, transporters, and environmental service workers. The goals for this group were to ascertain engagement with the tool and content, provide ease of access, and gauge whether the training was fun. These users typically were under union contract, so we needed to test whether we could also manage the time it took them to complete the training so that we met their contract stipulation.

Based on the two pilots, we were able to gather data around participation, engagement, and proficiency. We also sent out surveys to the participants to obtain feedback. Questions focused on whether they liked the tool, whether it was easy to use, what did and didn't work well, and so on.

In addition, we held post-learning meetings with the pilot teams to glean anecdotal feedback on what they liked and didn't like about the new modality. We wanted to hear real-world examples of how and when they were accessing learning on the job and the impact this option had on their daily work. We also wanted to know things like: Did this modality support or interrupt their work? Were they accessing learning during breaks? Did they use their own mobile device or shared PCs? Would they have preferred to compress the total learning time by receiving more questions at a time? How did they process the support assets for incorrect questions? Did certain assets work better than others? What were their feelings about the automated reminders?

Finally, because the pilot groups comprised caregivers in different job functions across the region, they were able to provide feedback that we could use to address concerns when we rolled out the new program to the entire population of learners. They gave us insights that we could use to help garner buy-in later.

Feedback is positive

Pilot participants said they liked the new modality and having access to learning on their mobile devices. What's more, they appreciated how the new setup reduced the amount of training time by more than two-thirds, which in this case was an hour.

An unforeseen outcome was that caregivers liked the idea of being able to test out of the content they could prove they already knew and only receive learning on content for which they needed a refresher. That not only saved time but also created a more personalized experience for them.

With the findings in hand, we were able to articulate a return on investment of $4 million in productivity savings each year for each enterprise-wide course (see figure). Other key benefits were a rise in user proficiency, an increase in real-time actionable analytics that would help leaders know what sort of support caregivers need during and after training, and a boost in engagement with the tool over traditional e-learning.

What's the Price of Learning?

Productivity Savings for Annual Compliance, Privacy, and Security Education

Traditional Learning		Microlearning	
1.5	Hour SCORM course	0.51	Hour (50 questions)*
103,866	Number of workers	103,866	Number of workers
40	Avg. worker hourly rate	40	Avg. worker hourly rate
$6,231,960		$1,731,100	

*0.41 hour to answer 50 questions at 30 seconds each, plus 0.1 hour to retry missed questions and review answers

The impact for the learning team was a reduction in development time. Because we had already completed the instructional design for the existing traditional e-learning course, we only needed to tap the content and media developers on our team to extract and repurpose content into the individual assets that we would use as support for each question. For any new assets, this group partnered with subject matter experts and was able to build out all the assets needed within a one-month timeframe.

Another bonus was that due to the automated prompts in the tool and the reporting, we ended up spending less time sending reminders to caregivers that they needed to complete their training.

Simply put, our rollout of 2020 compliance training using microlearning was a success. We were able to implement a new digital modality, slash the cost to the organization, and increase user proficiency that was backed by real-time data. We plan to deploy this new microlearning option of our hazard communication and caregiver compliance training to all existing caregivers, providers, and volunteers. As we do, we will continually review and update the support assets for each question. For example, for questions that have text or audio clips, we'd like to make new one-minute videos.

We also will explore other content areas we can transform into a microlearning experience. We anticipate targeting a few small compliance areas, such as patient privacy, or specific leadership areas, such as how to give feedback. At the same time, we want to remain mindful that we don't slip into employing this solution for everything. It's not always going to be a good fit, and with overuse, it may lose its engagement advantage. So, while microlearning is not the silver bullet for all training, it is one instrument in our L&D toolkit that enables us to provide just-in-time, personalized learning.

Darci Hall is vice president and chief learning officer for Providence; darci.hall@providence.org.