Improving Oregon's Health:
Recommendations for Building a Healthcare Workforce for New Systems of Care

Brief Report from the Oregon Healthcare Workforce Committee to the Oregon Health Policy Board

DRAFT
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Executive Summary

In May 2011, the Oregon Health Policy Board requested that the Oregon Healthcare Workforce Committee identify and describe the workforce models and health care professional competencies best suited to support promising new systems of care delivery and to recommend strategies to encourage adoption of promising workforce models and development of the associated competencies among Oregon's workforce. To meet these goals, the Committee reviewed the existing literature and recommendations from national bodies. It also conducted interviews with over thirty healthcare professionals, educators, health system administrators, and policy experts, whose accomplishments in health care are known regionally and nationally as well as within the State of Oregon.

The Committee strongly endorses interprofessional and team-based care as optimal methods for patient-centered primary care homes and Coordinated Care Organizations to achieve the clinical and financial outcomes of the Triple Aim: comprehensive and coordinated whole-person care, improved efficiency and better patient health. Key competencies associated with this model include individual skills with collaborative practice, health information technology (HIT), and communication, as well as organization- or system-level capacities such as flexible reimbursement, operational and managerial supports, and community engagement.

The Committee's initial recommendations for fostering the adoption of interprofessional, team-based care and associated competencies in Oregon are in three categories: policy, education, and practice. The most important and urgent in each category are listed below; additional recommendations can be found in the body of the report:

- *Policy*: Establish and expand pilot programs to test alternative payment models that enable flexible use of the healthcare workforce (e.g. global budgets for Coordinated Care Organizations, bundled payments for acute and post-acute care, and salaried providers).
- *Education*: Set expectations for ongoing and sustainable collaboration between academic/training/education communities and health care employers, so that educational experiences will be more connected and interdependently functioning in providing health care services.
- *Practice*: Foster a collaborative, egalitarian workplace culture to assure the successful implementation of team-based care in existing practices.

I.   Introduction

The Oregon Health Care Workforce Committee (Committee) was established in 2009 to develop recommendations and action plans for training, recruiting and retaining a health care workforce that can meet the needs of new systems of care delivery, as well as the demand for care in the next decade. In May 2011, the Oregon Health Policy Board charged the Committee to describe the workforce models and health care professional competencies needed to support promising new systems of care delivery, in particular patient-centered primary care homes and Coordinated Care Organizations. The Committee was also asked to recommend strategies to encourage adoption of promising workforce models and development of the associated professional competencies among Oregon's workforce. This brief report summarizes the Committee's analysis and recommendations.

II.   Background – New Systems of Care Delivery

Health reform initiatives in Oregon and the rest of the nation require changes in how health care is delivered and financed. The drive for reform is familiar to many: lack of coordination and integration among mental, physical, specialty, and other kinds of health care often results in frustration and poor outcomes for patients; fee-for-service reimbursement incents illness ("sick") care rather than health maintenance or prevention; and health care costs are unsustainably high and increasing for families, employers, and government.

Governor Kitzhaber, the Oregon Legislature, Oregon's Health Policy Board and the Oregon Health Authority are working with partners on two closely related initiatives to reform care delivery in the public sector: patient-centered primary care homes and Coordinated Care Organizations, as described in HB 3650, known as the Health Care Transformation Initiative.

- Patient-centered primary care homes (PCPCHs) are being implemented across the country to achieve the "triple aim" of better health outcomes, improved patient experience, and reduced costs. PCPCHs achieve these goals through a focus on wellness and prevention, coordination of care, active management and support of individuals with chronic conditions and other special health care needs, and a patient and family centered approach to all aspects of care. Oregon standards for PCPCHs were developed in 2010 and the Health Authority has just launched a process to recognize primary care homes and qualify them for enhanced reimbursement for Medicaid patients. The state aims to make patient-centered primary care homes available to 75% of Oregonians by 2015.

- Coordinated Care Organizations (CCOs) are intended to integrate physical (including hospital and specialty), behavioral, and oral health care for Oregon Health Plan members

and act as a single point of accountability for the health of the populations they serve. CCOs will be reimbursed for OHP services through global budgets designed to cover all types of care, allowing them the flexibility to allocate resources toward the care and provider types as best suits population needs. They will be held accountable for their performance on each aspect of the triple aim through quality measures and contracted performance standards, currently in development. PCPCHs will, in many cases, be central to the CCO's clinical delivery system.

Both of these models require healthcare professionals to work in new ways with each other and with patients. These realities raise critical questions of how many health workers of what kinds will be needed and what core competencies will be essential to make their work effective and efficient in the new systems of care.

III.   Workforce Competencies and Models from National Literature

In its 2001 report, Crossing the Quality Chasm: A New Health System for the 21st Century, the Institute of Medicine (IOM) stated the importance of preparing the health care workforce to make a smooth transition into a redesigned health care system. Among the recommendations related to health care workforce education was the need to teach evidence-based practice and provide opportunities for interdisciplinary training.

In follow up, the IOM (2003) convened a summit to identify a core set of competencies integral to providing safe, high quality and accessible health care. The core competencies include the ability to provide patient-centered care to diverse populations, work in interdisciplinary teams, employ evidence-based practice, apply quality improvement, and utilize informatics.

Since the publication of the IOM's report, additional efforts have further delineated health care workforce competencies, role adaptations, and changes in health profession education needed for new models of health care delivery.

Interprofessional Competencies

Eloranta (2009) observed that "the clinical environment has evolved beyond the limitations of individual human performance." Health care workforce shortages, a growing, aging and diverse population, greater numbers of people with chronic health conditions, and advances in medical science and technology combined with redesigned delivery systems have created an opportunity for health care professionals to engage in collaborative, interdisciplinary teams to improve access, quality and patient outcomes, and to increase their own job satisfaction.

This interprofessional team-approach to health has been defined as "a partnership between a team of health professionals and a client in a participatory, collaborative and coordinated approach to shared decision-making around health issues (Orchard, Curran, Kabene, 2005)." Experts have identified that transforming current practices to team-based care necessitates a change in health profession education; away from isolated pathways and traditional roles to an approach that facilitates collaboration, communication and coordination across professions and specialties. (Safety Net Medical Home Initiative, 2011; Bridges, Davidson, Odegard, Maki, Tomkowiak, 2011; Commission on Education of Health Professionals for the 21st Century, 2010; Crabtree, Nutting, Miller, Stange, Stewart, Jaen, 2010; Institute of Medicine Forum on the Future of Nursing: Education, 2010)

The Canadian Interprofessional Health Collaborative (2010) described six competency domains to prepare health care professionals and students for effective interprofessional collaboration: interprofessional communication; patient/client/family/community-centered care; role clarification; team functioning; collaborative leadership; and interprofessional conflict resolution.

The Interprofessional Education Collaborative (IPEC) convened an expert panel (2011a) to develop competencies for interprofessional practice. Four competency domains were identified: values and ethics for interprofessional practice; roles and responsibilities for care providers in a collaborative practice; effective interprofessional communication; and interprofessional teamwork and team-based care for shared problem solving and individual and team performance improvement. Based on these four competency domains, the IPEC, the Health Resources and Services Administration and philanthropic organizations convened a leadership conference to develop an action plan for incorporating these competencies into health profession education and health care delivery systems (2011b).

Communication Competencies

Timmons and O'Leary (2004) reported that communication-related issues were the most frequently reported root cause of sentinel events between 1995 to 2003 in JCAHO-accredited health care organizations. The IPEC (2011a) identified that communication patterns and professional jargon used in current health practices create barriers to sharing professional expertise to improve patient care. Additionally, experience with interprofessional communication is often missing in health profession education (Crabtree, Nutting, Miller, Stange, Stweart, Jaen, 2010).

New models of health care delivery require communication competencies that enable all interprofessional team members to voice concerns, use a common language for team communication, resolve interprofessional conflicts, use electronic health records effectively, and present information to patients and their families in ways that can be understood (IPEC, 2011a). Communication-related competencies and the effective use of communication tools and techniques have been identified as key to team development, building trust and a culture of patient safety, and improving patient outcomes, patient experiences, job satisfaction, and organizational learning and efficiencies (Bello, 2011; Blash, Dower & Chapman, 2011; IPEC, 2011a; Mauksch, 2011; Crabtree, Nutting, Miller, Stange, Stewart, Jaen, 2010; Eloranta, 2009; Suter, Arndt, Arthur, Parboosingh, Taylor & Duetschlander, 2009; Institute for Health Care Improvement, n.d.).

Computer Literacy and Health Information Technology Competencies

Electronic health records are considered a crucial component of health reform efforts in improving systems of care, improving communication with patients and between providers, reducing costs through greater efficiencies, improving clinic workflow, and providing data to improve patient outcomes (Safety Net Medical Home Initiative, 2011; Hummel, 2010; OHWI, 2010; Shaller, 2007). To accomplish these goals, national and professional associations have recommended that health care professionals possess a basic set of computer, information literacy and information management competencies for the safe, effective and efficient use of electronic health records (Technology Informatics Guiding Education Reform Initiative, 2009; AHIMA & AMIA, 2005).

The Oregon Board of Nursing has recognized the role of electronic health records in patient care by including regulatory language in the Oregon Nurse Practice Act (OAR 851-045-004(4)(a-b), which requires nurses to have competencies in nursing informatics and related technologies.

Other Professional Competencies

Additional workforce competencies associated with emerging health care delivery models include cultural competency (communication and other skills necessary to provide appropriate and effective care to individuals from different backgrounds) (Like, 2011; Jungnickel, Kelley, Hammer, Haines, Marlowe, 2009; Saha, Beach,Cooper, 2008), quality improvement skills (Safety Net Medical Home Initiative, 2011) leadership and change management skills (Institute of Medicine, 2011; Crabtree, Nutting, Miller, Stange, Stewart, Jaen, 2010) and proactive population-based care practices (Crabtree, Nutting, Miller, Stange, Stewart, Jaen, 2010; Ginsburg, Maxfield, O'Malley, Peikes & Pham, 2008).

Transforming Health Professional Education

Hackbarth and Boccuti (2011) advocated that the content of health profession education needs to match anticipated needs in order to develop an effective and sustainable health care system. Traditionally, health profession education programs establish curricula based on accreditation standards with new content added over time. This approach has disadvantages in a rapidly changing health care environment and limits opportunities for innovation. The Institute of Medicine's report on The Future of Nursing: Leading Change, Advancing Health (2011), stated, "The explosion of knowledge and decision-science technology also is changing the way health professionals access, process, and use information. No longer is rote memorization an option. There simply are not enough hours in the day or years in an undergraduate program to continue compressing all available information into the curriculum."

The Commission on Education of Health Professionals for the 21st Century (2010) found that health profession curricula reflect historical legacies that drive learning objectives. In contrast, learning objectives that drive curriculum allow for a competency-based approach and inquiry-based learning which promote critical thinking, problem-solving, leadership skills, professional responsibility and innovations in health care delivery (Commission on Education of Health Professionals for the 21st Century; 2010; Crabtree, Nutting, Miller, Stange, Stewart, Jaen, 2010; Jungnickel, Kelley, Hammer, Haines & Marlowe, 2009).

Many of Oregon's educational institutions are already moving toward interprofessional training. For example, Pacific University groups students from physical and occupational therapy, dental sciences, pharmacy, and physician assistant programs together to provide community-based services in Nicaragua, and the new OUS/OHSU Collaborative Life Science building to be built in Portland will include an interprofessional clinical simulation lab. Linn Benton Community College, Oregon State University, and Western University of Health Sciences' College of Osteopathic Medicine are partnering to offer an interprofessional education course to students of nursing, pharmacy, osteopathic medicine, dentistry, optometry, podiatry, veterinary medicine, and physician assistant students.

Transforming Practice

Movement towards a patient-centric, collaborative, team-based care models necessitates enhanced roles for health care professionals and support staff who contribute to patients' health (Crabtree, Nutting, Miller, Stange, Stewart, Jaen, 2010). Maximizing the potential of team-based care models by extending the roles of non-physician staff practicing at the full scope of their education and competency allows physicians the opportunity to focus their expertise on complex

cases, expands time to deliver evidence-based patient care, improves patient outcomes, improves job satisfaction, and may increase access and reduce costs of care (Blash, Dower & Chapman, 2011; Institute of Medicine, 2011; Safety Net Medical Home Initiative, 2011;Yarnall, Ostbye, Krause, Pollak, Gradison & Michener 2009; Laurant, Reeves, Hermens, Braspenning, Grol & Sibbald, 2004).

IV.   Workforce Competencies and Models from the Oregon Perspective

To complement the review of existing literature and recommendations from national bodies, the Committee conducted interviews with over thirty healthcare professionals and educators across the state, including physicians, nurses, medical assistants, clinic administrators, health systems executives, educators, and policy experts, most of whom have direct experience with interprofessional practice, implementing new approaches to health care delivery, or training professionals to new competencies. These interviewees were asked:

- What staffing models and provider competencies are needed to improve care delivery and outcomes for patients?
- What changes should Oregon's health care educational system and practice environment adopt to support the spread of new staffing models and professional competencies, particularly interprofessional collaboration?
- What workforce strategies would be most effective for helping to achieve health equity?

The interviews were transcribed by staff and analyzed by Committee members collaborating with an independent qualitative analyst to identify themes, challenges, and recommendations. Details of the methods and independent analysis are in Appendix A; key findings follow.

Individual Competencies

Oregon experts affirmed the importance of a team-based care model and associated professional competencies. As illustrated in the quotes below, interviewees argued that team-based care enables the processes and outcomes that patient-centered primary care homes and Coordinated Care Organizations are intended to achieve: comprehensive, integrated, whole-person care, improved efficiency and better patient health.

> ***Healthcare Executive:*** *"A strong primary care foundation is essential for an effective health care system…The Patient Centered Primary Care Home is now widely recognized as the model for strengthening primary care. It requires an interdisciplinary team."*

> ***Physician****: "A team-based model [is] focused on producing better outcomes for a defined population of patients. The MD doesn't necessarily need to see everyone."*

> *Healthcare Administrator: "[We have] an RN on every team. They do chronic disease management. Nurses spend 60-70% of time proactively managing these patients over the phone, in person, through educational seminars or motivational interviewing, etc. This has really improved our diabetic and depression patient outcomes."*

Oregon experts echoed the national literature when identifying specific competencies needed for interprofessional, team-based care included. Skills and qualities mentioned in the interviews included: leadership, conflict resolution, interprofessional cultural competency (to understand and respect the roles and skills of other professionals), quality improvement, and communication. For example, interviewees suggested:

> *Healthcare Administrator: "They [doctors] also need to know how to manage conflict and how to assist a team in resolving conflict and staying on task (leading a team, but not giving orders and allocating tasks so much as guiding the members)."*

> *Medical Educator: "We don't train physicians to be effective team players - The whole interprofessional team needs training in communication."*

Most interviewees felt that healthcare providers are not acquiring these important competencies as a part of their regular education. Some also suggested that future professionals are not getting sufficient training in prevention, early intervention, population focused care, and chronic disease management.

> *Healthcare Executive: "This goes back to the training programs: training people in what it means to be a member of the team and how best to interact with other members. It's a bit of a departure from traditional training with more of a focus on the sensitivity of how teams work."*

> *Medical Assistant: "[I don't] think that medical assistants are being trained to do the current version of their job (in community colleges as well as in proprietary trainings) – [We are] missing teamwork and skills for primary care homes."*

However, many interviewees acknowledged that faculty and students have few opportunities too see these models and competencies in action:

> *Physician: "There's a "train the trainer" concept involved here - Since the educators themselves don't have a lot of experience with the model described above, they can't really pass it on to their students."*

> *Healthcare Executive: "There are a lot of educational programs for teaching the correct team skills. The problem is more that students need to see those skills modeled in a work environment, not just taught in schools."*

A few participants noted that educational programs may find it difficult to incorporate new competencies into curriculums that are already very full or are constrained by national regulations (e.g. CMS restrictions on how much time medical residents must spend in hospitals) or accreditation standards.

Many consultants described similar roles to be filled on a primary care team, such as a primary care provider, a care coordinator and/or panel manager (depending on level), a medical assistant and a clerical assistant. However, several noted that there was no one-size fits all approach and that the ideal team is community-dependent:

> *Physician: "[Care] should be organized around the population, not around the providers. Then we need to figure out how to bring these people together and which competencies are necessary to meet the goals for a specific population."*

Organizational Competencies

Oregon experts went somewhat beyond the national literature by identifying several practice- or system-level competencies necessary for the successful implementation of new systems of care. While some of these have corollaries with the individual professional skills described above, they pertain to the practice environment rather than to individual practitioners.

Interviewees argued that irrational and counterproductive reimbursement mechanisms must change in order to provide the workplace flexibility required for team-based care.

> *Healthcare Administrator: "The current reimbursement model doesn't help for medical home or coordinated care organization-it becomes much less about the visit and much more about managing the population. If we keep paying for the visit, it's not as effective in maintaining a healthy population."*

> *Physician: "Some organizations are more prepared than others, but are hamstrung by reimbursement models. The payment models are strong disincentives to reinforcing the primary care centric approach."*

Consultants also suggested that an egalitarian, collaborative workplace culture would be necessary for establishing establish effective teams:

> ***Medical Assistant:*** *"We need to get rid of the old hierarchy and implement a more equal, team-based system - all team members need to feel that they and their work are important and valued, as well as the specifics of their role on the team. Top-down decision-making contributes to this problem."*

> ***Healthcare Administrator:*** *"The highest performing teams that they have are those who have gotten over the traditional hierarchy and are respecting all team members."*

> ***Physician:*** *"It's a hurdle to let the primary care physician out of the way and let the team take command. Providers have to learn not to be the boss and to work effectively in teams. This is more of a cultural issue."*

While individual practitioners need to know how to work within the team-based care model, organizations must have the technical infrastructure and operational capacity to support it.

> ***Physician:*** *"A good IT system is the glue that holds [coordinated care] together. [These models need] some form of regional health information organization (RHIO) system that allows patient records and other information to be widely and easily shared."*

> ***Physician:*** *"On a more practical level, we also need to figure out how to properly divide work, evaluate competencies, and determine optimum functionality of each team member. You need someone who's developed a good model for this sort of teamwork, and [I haven't] seen that before."*

> ***Healthcare Administrator:*** *"[We need to] get staff and clinics data on their population- their characteristics, needs, etc. This is a powerful motivator in beginning to brainstorm on how to address those needs."*

Oregon experts also mentioned community engagement as a key organizational competency both for building the appropriate workforce and advancing health equity.

> ***Physician****: "[Care] should be organized around the population, not around the providers. Then we need to figure out how to bring these people together and which competencies are necessary to meet the goals for a specific population."*

> ***Healthcare Administrator:*** *'It's important to [me] that [my] staff represents the clients that they serve. [We] work with the schools to try to get a workforce that's representative-then the staff themselves can be personal informants about the different cultures. Patients also become more comfortable this way.*

Physician: *"When the community runs the organization, then true health care equity happens."*

Finally, a few interviewees cited uneven distribution of professionals by geography and provider type as a major impediment to the creation of effective interprofessional teams:

Physician: *"[We have a] high concentration of doctors in the metro area and dramatically fewer everywhere else. We need to invest in more "mid-level" providers— perhaps we even have too many doctors. So much of the medical world is standardized these days that, after the initial diagnosis, a PA could potentially take over."*

V.   Recommendations

The overarching recommendation emerging from both national literature and conversations with local stakeholders is that Oregon must dramatically expand use of team-based, interprofessional care across the state. Development and dissemination of team-based care should be a priority on par with implementation of patient-centered primary care homes and Coordinated Care Organizations, since the success of those models depends in large part on highly competent provider teams. The Committee offers the following recommendations for achieving broad adoption of interprofessional, team-based care. Recommendations are presented separately for policy, education, and practice but several pertain to more than one sector. A table of these recommendations can be found in the Appendices.

Recommendations for Policy

- Establish and expand pilot programs to test alternative payment models such as global budgets for Coordinated Care Organizations, bundled payments for acute and post-acute care, and salaried providers.
(WHO: Policymakers, payers, and health systems)

- Develop job descriptions, scopes of work, competencies, and performance standards for "new" positions such as care coordinators, navigators, community health workers, etc.
(WHO: Regulatory agencies and policy-makers, in cooperation with health care organizations/employers and educational entities. (A Subcommittee of the Oregon Healthcare Workforce Committee has undertaken this work and will report to the Health Policy Board in January.)

- Provide opportunities for multi-payer alignment around promising models of flexible, outcomes-focused reimbursement.
(WHO: Policymakers and regulatory agencies)

- Revise job descriptions for existing categories of health care workers to reflect the nature of inter-professional, team-based care.
  (WHO: Regulatory agencies in cooperation with health care organizations/employers and educational entities)

Recommendations for Education

Interprofessional training and competency-based curricula are not new ideas in education. But the current health care environment demands a much broader and more rapid implementation of these concepts than has been seen to date. Strategies for increasing the relevance of education for interprofessional, team-based care include the following:

- Set expectations for ongoing and sustainable collaboration between academic/training /education communities and health care employers, so that educational experiences will be more connected and interdependently functioning in providing health care services.
  (WHO: Educational institutions and health care industry employers)

- Collaborate across disciplinary boundaries to develop and implement the same set of interprofessional competencies.
  (WHO: educational institutions, regulatory agencies, accrediting bodies, and professional societies. One possibility would be to use a joint waiver or similar process to approach the relevant accrediting bodies.)

- Develop shared methods for training and assessment of interprofessional competencies.
  (WHO: Educational institutions, regulatory agencies, and professional societies)

- Provide opportunities for faculty—not just trainees—to gain experience with interprofessional practice and new models of care via "experience" sabbaticals that allow faculty to return to the field, utilizing staff from health care organizations that have adopted new models as adjunct faculty, or other means.
  (WHO: Educational institutions and health care industry employers)

- Increase opportunities for interprofessional training, especially in clinical settings. Emerging patient-centered primary care homes, CCOs, and other innovative service delivery organizations would be ideal settings for interprofessional teams of health profession students to learn about and contribute to new models of care.
  (WHO: Educational institutions and health care industry employers)

Recommendations for Practice

- Foster a collaborative, egalitarian workplace culture to assure the successful implementation of team-based care in existing practices. While culture change takes time, practices hosting students coming from interprofessional training programs can use those students as change agents to help accelerate the process.
(WHO: Health system leaders and practicing professionals)

- Identify successful early adopters of team-based care models to assist practices with technology implementation and guideline development during the transition process.
(WHO: Industry leaders and professional societies)

- Prioritize investment in the information technology infrastructure needed to support communication within and across teams and sites of care, and to enable providers to identify and proactively manage clusters of patients with particular needs.
(WHO: Industry/health system leaders)

- Revise hiring and human resources practices to enable recruitment, retention, and evaluation of professionals engaged in interprofessional and team-based care.
(WHO: Industry leaders and health care employers)

VI.   Conclusions and Next Steps

New models of health care delivery, including CCOs and patient-centered primary care homes hold great promise for improving health status, increasing care quality, and controlling health care costs. In order to deliver on this promise, Oregon needs a health care workforce that has the individual and organizational competencies necessary to work together in interprofessional teams. This brief report summarizes national and state-level expert thinking on the most important competencies and provides some initial recommendations for cultivating those competencies via action in the sectors of policy, education, and practice.

The Healthcare Workforce Committee suggests an online survey or similar process to collect feedback on these expert recommendations from a broad range of stakeholders, particularly practicing educators/trainers, health professionals, health care employers, system administrators, and consumers who may not be actively involved in policy conversations. The survey process should invite feedback on the substance of the report's recommendations as well as on the best steps and venues for implementing those recommendations. The Healthcare Workforce Committee would be pleased to undertake this additional data collection and feedback step at the request of the Health Policy Board.

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Report Recommendations and Responsible Parties

X=Participant L=Lead	Policy Makers	Regulatory Bodies	Accrediting/ Licensing Bodies	Professional Societies	Health Care Payers and System Leaders	Health Care Provider Entities/ Employers	Academic/ Training Organizations
Policy Recommendations							
Establish and expand pilot programs to test alternative payment models	XL				X		
Develop job descriptions for new positions such as care coordinators, navigators, community health workers, etc.	XL	XL				X	X
Provide opportunities for multi-payer alignment around promising alternative models of reimbursement.	XI	XL					
Revise job descriptions for existing categories of health care workers to reflect the nature of inter-professional, team-based care.		XL				X	X
Education Recommendations							
Set expectations for collaboration between education communities and health care employers						XL	XL
Collaborate across disciplinary boundaries to develop and implement the same set of interprofessional competencies.		XL	X	X			X

Report Recommendations and Responsible Parties

X=Participant L=Lead	Policy Makers	Regulatory Bodies	Accrediting/ Licensing Bodies	Professional Societies	Health Care Payers and System Leaders	Health Care Provider Entities/ Employers	Academic/ Training Organizations
Develop shared methods for training and assessment of interprofessional competencies.		XL		X			XL
Provide opportunities for faculty to gain experience with interprofessional practice and new models of care.						X	XL
Increase opportunities for interprofessional training, especially in clinical settings						X	XL
Practice Recommendations							
Foster a collaborative, egalitarian workplace culture to assure the successful implementation of team-based care in existing practices.				X	XL		
Identify successful early adopters of team-based care models to assist practices with transition.				X	XL		
Prioritize investment in information technology infrastructure.					XL		
Revise hiring and human resources practices to enable recruitment, retention, and evaluation of professionals engaged in interprofessional and team-based care.					XL	XL	

Report Recommendations and Responsible Parties

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X=Participant L=Lead	Policy Makers	Regulatory Bodies	Accrediting/ Licensing Bodies	Professional Societies	Health Care Payers and System Leaders	Health Care Provider Entities/ Employers	Academic/ Training Organizations
Policy Recommendations							
Establish and expand pilot programs to test alternative payment models	XL				X		
Develop job descriptions for new positions such as care coordinators, navigators, community health workers, etc.	XL	XL				X	X
Provide opportunities for multi-payer alignment around promising alternative models of reimbursement.	XI	XL					
Revise job descriptions for existing categories of health care workers to reflect the nature of inter-professional, team-based care.		XL				X	X
Education Recommendations							
Set expectations for collaboration between education communities and health care employers						XL	XL
Collaborate across disciplinary boundaries to develop and implement the same set of interprofessional competencies.		XL	X	X			X

Report Recommendations and Responsible Parties

X=Participant L=Lead	Policy Makers	Regulatory Bodies	Accrediting/ Licensing Bodies	Professional Societies	Health Care Payers and System Leaders	Health Care Provider Entities/ Employers	Academic/ Training Organizations
Develop shared methods for training and assessment of interprofessional competencies.		XL		X			XL
Provide opportunities for faculty to gain experience with interprofessional practice and new models of care.						X	XL
Increase opportunities for interprofessional training, especially in clinical settings						X	XL
Practice Recommendations							
Foster a collaborative, egalitarian workplace culture to assure the successful implementation of team-based care in existing practices.				X	XL		
Identify successful early adopters of team-based care models to assist practices with transition.				X	XL		
Prioritize investment in information technology infrastructure.					XL		
Revise hiring and human resources practices to enable recruitment, retention, and evaluation of professionals engaged in interprofessional and team-based care.					XL	XL	

Report Recommendations and Responsible Parties

Appendix A - Experts Consulted for Oregon Perspective

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Many thanks to these individuals for their time and expertise!

Appendix B – Consultant Interview Guide

1. Primary care homes, Coordinated Care Organizations, and other new models of health care delivery may require providers to perform new functions or work together in new ways. In your experience or opinion, **what kinds of staffing models are best suited to improving care for patients and making care delivery more effective? What kinds of provider skills or competencies are needed to support those models?**

2. **Does Oregon have the appropriate educational and practice framework in place to implement and work within the kinds of models identified above? If not, what changes are needed?**

3. **What steps are necessary to make needed changes in either the practice or educational environment for health care workers to attain and maintain professional and inter-professional skills, competencies, and inter-professional relationships?**

4. Health care transformation may require new systems or practices of health care delivery that prevent and/or address disparities across a number of demographic variables such as race, ethnicity, language, education, disability, gender, or sexual orientation. In your experience or opinion, **what workforce strategies (workforce models, composition, provider skills, etc.) would be the most effective for achieving health care equity?**

5. Is there anyone else—a colleague for instance-- you might recommend we consult regarding these questions?

Changing Oregon's Healthcare Delivery Model: Lessons from the OHPR Consultant Interviews

A Qualitative Analysis

10/12/2011
Center For Outcomes Research, Providence Health and Services
Analyst: Lauren Broffman

I. INTRODUCTION: WHY QUALITATIVE ANALYSIS?

The solicitation of feedback from professionals is a crucial step in strategic planning, and as the Office of Oregon Health Policy and Research (OHPR) develops a framework to guide the future of healthcare policy in Oregon, planners need access to the perspectives of those who work in healthcare every day.

Quantitative data collection methods - such as surveys - can be helpful in gathering certain types of answers, but responses to a survey are generally closed-ended and are determined by the questions that are asked. Open-ended responses, such as those gathered in a qualitative interview, allow the respondent more freedom to express opinions and ideas. These open-ended responses can be particularly useful in strategic planning, because they allow planners to access the creativity and insight of those that they consult.

METHODS

In order to tap into the expertise and ingenuity of Oregon's healthcare professionals, OHPR conducted 30 interviews with doctors, nurses, medical assistants, medical administrators, executives, educators, and healthcare experts at the state level. Almost all of the interviewees had cross-disciplinary backgrounds and fell into more than one professional category, offering insight from multiple perspectives. The result of this endeavor is a wealth of ideas, valuable critique, and constructive solutions all collected in written transcripts. These transcripts represent an overwhelming amount of information that would be difficult for an individual reader to synthesize. However, qualitative analytical techniques can be employed to interpret large quantities of text-based data - such as open-ended responses or interview transcripts - because qualitative analysis organizes the data in a systematic way, making it easier to comprehend as a whole. This analysis will allow OHPR to collectively and systematically assess the valuable contributions that each consultant made during the interview process.

This report summarizes the results of a qualitative analysis of the OHPR Consultant Interviews dataset. The analysis was completed in two steps: First, a content coding dictionary was created that would enable analysts to identify common themes among interviews. Using a free-form coding technique, each discrete response was given a label derived from a specific key word or concept found in the response. These labels comprised the first draft of the coding dictionary, which was then examined for conceptual overlap, and any redundant codes were combined and categorized. Second, using this coding dictionary, a textual content analysis of all data from the consultant interviews was conducted to identify recurring themes that were present across all interviews combined, or any strikingly divergent opinions that appeared[1]. This data-set contained a significant amount of agreement from participants; illustrative quotes were pulled from the transcript to highlight the findings below in participants' own words. The quotes are intended to help validate the presence of the concepts across multiple sources, so no specific finding included multiple quotes from the same participant.

While this particular type of analysis is adept at uncovering major overlying themes, individual responses are sometimes lost. The consultant interviews are worth reading individually for the sake of the unique ideas and perspectives that they elicited. Nevertheless, this analysis was able to pinpoint emergent themes within the body of participant responses and can answer the question: *Overall, what*

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[1] The coding dictionary is included in this report as Appendix A

do key healthcare players in Oregon really think is the optimal model of care, and what educational and practice changes will facilitate it?

II. OREGON'S HEALTHCARE PROFESSIONALS ADVOCATE FOR TEAM-BASED CARE

The overwhelming majority of respondents indicated that a collaborative or team-based approach is the ideal staffing model. These respondents are convinced that the multidisciplinary team-based model will improve care and will make care delivery more effective.

Many respondents had experience in working within a team-based model, whether in Oregon or in another state. Some had even been a part of an implementation process that instituted a team-based system. Therefore, these interviews provided rich insight into the ways in which the team-based care is already improving care delivery when compared to older organizational designs. These improvements included delivering more effective care, streamlining workflow and costs, and reducing health disparities.

III. WHY A TEAM-BASED MODEL?

Team based models place a focus on prevention, therefore providing more effective care: A majority of key informants emphasized the importance of preventive care in a functioning and sustainable healthcare system. These informants saw value in a well-communicating team that includes doctors, nurses, medical assistants, and various other professionals (like nutritionists and social workers) because these teams are better equipped to provide primary care, disease management, and continuity of care:

> *Healthcare Executive: "A strong primary care foundation is essential for an effective health care system…The Patient Centered Primary Care Home is now widely recognized as the model for strengthening primary care. It requires an interdisciplinary team."*

> *Healthcare Administrator: "The medical home model…works best for tracking patients' health concerns, follow-ups, referrals, and preventative care. [We've] also gotten positive feedback from patients on this."*

> *Healthcare Executive: "Having a nurse practitioner onsite and able to both see the client in their setting and communicate directly with the staff nurse and caregivers can help ensure continuity of care and resolution of possible issues."*

Collaborative care also employs team members who specialize in techniques like motivational interviewing and patient coaching, which encourage patients to take an active role in managing their own health:

> *Healthcare Administrator: "[We have] an RN on every team. They do chronic disease management. Nurses spend 60-70% of time proactively managing these patients over the phone, in person, through educational seminars or motivational interviewing, etc. This has really improved their diabetic and depression patient outcomes."*

Team-based models encourage organizational efficiency: Team-based models streamline workflow, maximize efficiency, and allow for professionals to be working at "the top of their license," in other words, making the most effective use of their skills and capacities:

> *Doctor: "Physicians [can be] used just for real scientific and licensure knowledge; all other care performed by nurses, assistants, health coaches, or community health workers."*

> *Doctor: "A Team-based model [is] focused on producing better outcomes for a defined population of patients. The MD doesn't necessarily need to see everyone. For example, for many chronic conditions (like diabetes), management by a non-MD can be just as-if not more-effective in delivering care…it is cost effective if you are using people who are sufficiently skilled/trained and not overqualified for the particular service."*

This concept also applies to how specialists are used. Informants suggested that traditional models sometimes result in general care that is provided by a specialist—this is an inefficient and expensive way to deliver primary care, because specialists tend to cost more and are often not embedded within the primary care infrastructure. In contrast, collaborative care models promote using specialists as consultants when a specific skill set is required:

> *Doctor: "Specialists should be used to answer very specific technical questions and freed from more consistent care, such as patient follow-up."*

> *Doctor: "[We should] use specialists to train primary care physicians to be team-based semi-experts on-site. Clearer guidelines for what constitutes a sufficient need for a referral to a specialist - less direct care and more consultation/training activities."*

IV. IMPLEMENTATION

One key to collaborative care implementation requires changing the organizational culture: Though respondents found ample justification for team-based healthcare, they also noted that expanding these practices requires a drastic change to the current approach to the organization of healthcare centers – in short, a culture overhaul. One aspect of introducing a collaborative care delivery model involves re-examining the hierarchy that characterizes traditional practices. Respondents underscored the notion that for a team to be effective, a decentralized organizational structure must be implemented:

> *Medical Assistant: "We need to get rid of the old hierarchy and implement a more equal, team-based system - all team members need to feel that they and their work are important and valued, as well as the specifics of their role on the team. Top-down decision-making contributes to this problem."*

> *Healthcare Administrator: "The highest performing teams that they have are those who have gotten over the traditional hierarchy and are respecting all team members."*

> *Doctor: "It's a hurdle to let the primary care physician out of the way and let the team take command. Providers have to learn not to be the boss and to work effectively in teams. This is more of a cultural issue."*

> *Medical Educator: "We don't train physicians to be effective team players - The whole inter-professional team needs training in communication."*

Though there was consensus on the importance of decentralization, it is clear that a successful team-based model still requires an element of good management and leadership:

> *Healthcare Administrator: "They [doctors] also need to know how to manage conflict and how to assist a team in resolving conflict and staying on task (leading a team, but not giving orders and allocating tasks so much as guiding the members)."*

> *Doctor: "[We] have to have a chain of command at the same time as you have empowerment. Though used to the model of where the doctor gets the final says, and even though that might be the case at the end, the process needs to be more collaborative overall."*

> *Doctor: "Many people leave because they feel unfairly treated, underappreciated, or discriminated against, so better leadership is needed to treat people better to keep them."*

> *State Policy Expert: "In the practice field, leadership is key. Even if we have all the technical assistance possible, without a strong leader in the group, it's no good."*

Respondents noted that accomplishing this kind of inter-organizational culture change would be no easy task. They did identify a place to start: informants advocated the incorporation of both management and teamwork skills into the various educational curriculums for physicians, nurses, medical assistants, and any other professional that would join a team under this model. The consensus was that "technical and medical skills are no longer sufficient" – interpersonal and management skills are paramount to ensuring the effectiveness of the system and to providing good care to the patient. Furthermore, being an effective team requires that each member understand what other members of the team bring to the table, so training across disciplines is another valuable component to the implementation of a team-based model:

> *Healthcare Executive: "This goes back to the training programs: training people in what it means to be a member of the team and how best to interact with other members. It's a bit of a departure from traditional training with more of a focus on the sensitivity of how teams work."*

> *State Healthcare Director: "Cross-disciplinary classes could also be helpful-a setup where students in different specialties work together to solve cases, so they can get used to considering factors outside their own specialty."*

> *Doctor: "Cross-division, cross-specialty, cross-discipline, and cross-patient communication provides best cultural development and security for organization."*

Numerous consultants noted that to effect this alteration in the healthcare curriculum, there is a step that must be taken before redesigning education programs - training on teamwork and team-based models will be ineffective unless the medical education system can align educators with new goals:

> *Doctor: "There's a "train the trainer" concept involved here - Since the educators themselves don't have a lot of experience with his model described above, they can't really pass it on to their students."*

Lastly, some informants suggested that because the healthcare system is changing so rapidly and the educational system traditionally takes longer to change, practical experience is a key transitional piece of preparation for a career in health care. These respondents said that it is important to give future doctors and nurses access to hands-on, real-world training that will equip them to join a collaborative team and give them experience in delivering care within a team-based model:

> *Medical Assistant: "[I don't] think that medical assistants are being trained to do the current version of their job (in community colleges as well as in proprietary trainings) – [We are] missing teamwork and skills for primary care homes."*

> *State Healthcare Director: "[Implement] internships within the community centers, so students can learn the integrated approach. Identifying centers that have these models and setting up internships there could help provide the necessary training better than simply learning about the theory in the classroom."*

Another key to collaborative care implementation is to tailor care to population need:

There was considerable consensus among key informants that the success of the team-based model is contingent upon understanding the population and subsequently designing the team to serve it. One of the benefits of the team-based model is that capitalizes on proactive medicine instead of reacting to patients once they are sick. Proactive preventive care depends upon a thorough and objective understanding of the population that any given team will be serving; data should be used to determine specific healthcare needs:

> *Community Healthcare Executive: "[We need to] understand data and how to manipulate registries, and then use that information to develop care plans for patients. This is more proactive work than just reacting to who comes in."*

> *Doctor: "[We need to know] prevalence of conditions/needs based on population analysis. Some less populated areas will lead service system to seek out non-medical personnel to meet some needs. Community health aids (community healthcare worker), community members who are trained to provide some rudimentary clinical services, w/ distance support (a la Alaska), may be very useful."*

> *Doctor: "[We need] better use of data to find population clusters who suffer from similar chronic conditions."*

> *Healthcare Administrator: "[We need to] get staff and clinics data on their population-their characteristics, needs, etc. This is a powerful motivator in beginning to brainstorm on how to address those needs."*

Effectively tailoring care to need requires a focus on health equity:

Another tenet of designing the care to meet the needs of the community is having care organizations making efforts to solicit input from the community itself. Participants emphasized the importance of meeting community need, providing good "customer service," and valuing and responding to community feedback. Direct interaction with the community enables providers to better understand the needs of patients and encourages health equity. As one consultant put it:

> **Doctor:** *"When the community runs the organization, then true health care equity happens"*

A team designed to meet the needs of the community would include professionals that address cultural needs such as interpreters, community health workers devoted to outreach, or staff devoted to managing whatever chronic conditions are prevalent within the population.

> **Healthcare Executive:** *"Most critical to health care equity is recruiting a diverse health professional workforce. For the professions, especially nursing and medicine, who is accepted into the professional schools is a very critical starting point."*

Many consultants advised that an important design facet includes recruiting professionals with diverse backgrounds to increase the scope of cultural sensitivity that the team offers. The best way to accomplish this goal was to be embedded within the community:

> **Healthcare Administrator:** *'It's important to [me] that [my] staff represents the clients that they serve. [We] work with the schools to try to get a workforce that's representative-then the staff themselves can be personal informants about the different cultures. Patients also become more comfortable this way.*

Lastly, informants perceived that the interpersonal communication skills that are required for a successful team-based model are also vital for communication with patients, and successful communication with diverse patients will reduce health inequities:

> **Healthcare Administrator:** *"We need more focus on the practice end of training to really work with patients, not just book learning about different cultures. Staff should have general knowledge about the different diversities and cultures, and then use their practical application skills to tailor the general knowledge to specific patients."*

> **Doctor:** *"This is huge. We have to build teams that reflect the communities that we serve in order to close health disparities. These reflections can be based on ethnicity, language, trauma recovery, socioeconomic backgrounds, etc. This helps health centers give tailored, understanding care to their patients. "*

V. CHALLENGES FOR OREGON: BARRIERS TO CHANGE

Informants agreed that team-based care delivery models would significantly improve Oregon's healthcare system, and they also agreed on some of the changes that would need to be made in order to implement team-based care. Nevertheless, these informants also identified systemic obstacles to team-based care:

1. Reimbursement and payment mechanisms

Many respondents agreed that the current reimbursement system does not allow for the flexibility that is required in team-based models. As reimbursement structures continue to drive staffing decisions and to define how medicine is practiced, collaborative models become more difficult to implement:

> *Healthcare Administrator: "The current reimbursement model doesn't help for medical home or coordinated care organization-it becomes much less about the visit and much more about managing the population. If we keep paying for the visit, it's not as effective in maintaining a healthy population."*

> *Doctor: "Some organizations are more prepared than others, but are hamstrung by reimbursement models. The payment models are strong disincentives to reinforcing the primary care centric approach."*

> *Doctor: "If we detach reimbursement from reality, we are very likely to fail"*

Despite this hurdle, some informants expressed hope that moving towards bundled payments or outcomes-based reimbursements might provide a solution. Additionally, participants suggested providing financial incentives for changes to the educational curriculum or to practice settings; these incentives might be a realistic strategy to hasten the inevitably sluggish overhaul of an entire healthcare system.

2. Standardization Challenges

There was an explicit and prevalent call for standardization in Oregon for these new models, both in educational curriculum and for protocol in practice settings:

> *Medical Educator: "The more you can standardize key components of protocol the safer it is… [there] needs to be a standard of compliance that has some level of evidence based effectiveness."*

However, the notion that team-based care is most effective when it is unique to the community it serves conflicts with the conformity inherent in standardization. Therefore one of the challenges moving forward will to address these conflicting values: how does one standardize something for which there is a "no one-size-fits-all" (a common phrase throughout the interviews) model? One consultant exemplified this challenge in regard to rural settings:

> *Doctor: [We] need to have a careful balance between requiring performance standards and actually getting care where it's needed, as rural clinics can often struggle with getting specific certifications."*

3. Political and Systemic Challenges

Consultants continually exhibited an understanding that changing the healthcare industry is not an isolated task. There are many political considerations that present challenges:

> *Healthcare Administrator:* *"The medical profession cannot stop the social/structural sources of poverty and inequity; there needs to be a larger effort between medical, government, and other social structures."*

> *Doctor:* *"In general, scope of practice needs to be readdressed for all levels. [I] realize this is going to be a huge political issue, but we won't get anywhere without addressing it."*

Additionally, some deeply-rooted institutional precedents, such as the exorbitant cost of a medical school education, present a significant barrier to change. While a handful of consultants mused that reducing student debt could facilitate the implementation of coordinated care and reduce health disparities by addressing historically overlooked community needs – like the lack of physicians in rural settings—most were agreed that there is no quick fix.

VI. CONCLUSIONS: ADVICE FROM THE FIELD

1. The ideal model of care is a team-based, collaborative model that focuses on primary care, preventive care, and disease management. The care teams should be multidisciplinary, and different professionals should play different roles in care coordination and delivery; teams can include doctors, nurses, auxiliary professionals, nutritionists, and social workers.

2. The hierarchical structure that is prevalent within medical care delivery today should be revisited; collaborative models work best when each team member is respected for the role that he or she provides.

3. Education of healthcare professionals should prepare them to participate in team-based care. Future healthcare workers should gain communication, teamwork, and management skills.

4. The success of a team-based model is dependent upon its sensitivity to the needs of the community it serves. Practices should be linked to the community and should have systems in place to receive feedback and to respond to diverse needs. If implemented effectively, team-based care has the potential to reduce health disparities.

5. Reform in healthcare delivery is inextricable from payment reform and from social reform as a whole. Any successful approach to healthcare policy change will take political, social and financial contexts into account.

This qualitative analysis has identified several emergent themes as circulated through the majority of participant narratives. It is clear from this process that most consultants that were interviewed would agree with the ideas and suggestions that have been expressed above as the dominant messages; however, the limitation to content analysis is that it often has to minimize individual experiences for the sake of identifying these overarching concepts. Because of the prolific amount of professional knowledge, practice, and skill that each consultant brought to the interview table – from working in medical homes to state-run organizations to offering practice and organizational anecdotes from other parts of the country, there is no doubt that this data-set is full of equally valuable specificities. This report is best used as a complementary tool to the individual assessments of interviews simultaneously being conducted by OHPR.

Appendix A -OHPR Coding Dictionary

Challenges – any consultant description of barriers to change and/or implementation of his/her proposed model

Cultural Competency – any reference to the necessity for cultural sensitivity and/or the ability to effectively care for a particular cultural group

Organizational Culture Change – any description of the need to change an existing norm

Population Data Usage – any reference to reliance on statistics and/or hard numbers to better understand a given population

Community Need – any reference to designing care and/or driving change that includes designing care and care models to the needs of the community

Diversity – any reference to being inclusive of a variety of cultures (race, ethnicity, socio-economic), especially in regards to improving care delivery

Efficiency – any reference to streamline of workflow or making healthcare models more efficient

Incentivizing – any reference to driving change with monetary incentives

Leadership – any reference to the importance of having effective managers and leaders among teams

Payment Mechanisms – any reference to reimbursement structures or any other compensation system

Recommendation – any general recommendation to drive proposed changes

Team composition – any reference to an effective composition of a team, especially beyond traditional role, e.g. social workers, patient navigators, administrative assistants, and the role of specialists

Standardization – any reference to the necessity of standardization for a proposed model of change, be it practice protocol, education, or otherwise

Systemic Barriers – challenges of change and/or forward motion that were related to or a result of the macro-level healthcare system and any related social structures

Team-Model Benefit: Coordination of Care – any reference to the benefit or effectiveness of a team-based model relating to how care can be integrated or coordinated for any given patient

Team Based Care - Beyond Medicine – any reference to the value of a functioning team that extends beyond the scientific practice of medicine, including interpersonal skills

Team model Benefit - Care Delivery – any description of the types of care or care delivery that is or would be provided by the team-based model

Team model Competency -Management/Customer Skills – any reference to team-based care that includes interpersonal competencies

Team Model Functionality – Communication – any reference to the importance of communication skills for team-based care models, either between members, individual patients, or the community at large

Team Model Implementation – Hierarchy – any reference to the role that hierarchy plays in implementing integrated care models

Training/Education - Clinical or Onsite – any reference to more real-world, hands on, or outside the classroom training for students of any medical profession

Training/Education – Team Based Care – any reference on how to train medical students and/or professionals to effectively function as part of a team

Training/Education - Cross Discipline - any reference to multifunctional training across different professional disciplines or skill sets

Training/Education – General – any other relevant reference to training or education that does not fit into the above categories

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