RCRHS
Réseau canadien sur les ressources humaines en santé

CHHRN
Canadian Health Human Resources Network

Welcome to Fireside Chat # 401
June 17, 2014 1:00 – 2:00 PM Eastern Time

(Teleconference open for participants at 12:50 PM ET)

Moving from Barriers to Facilitators:

Funding and Remuneration Models that better Optimize Health Professional Scopes of Practice

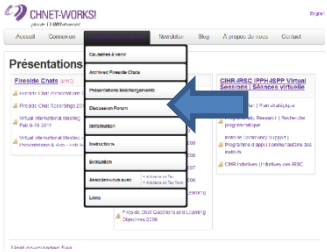
Advisor on Tap:

Dr. Gillian Mulvale,
Assistant Professor,
Health Policy and Management,
DeGroote School of Business,
McMaster University

CHNET-WORKS!

www.chnet-works.ca
Population Health Improvement Research Network
University of Ottawa

Housekeeping : how a fireside chat works…



Step #1 : *Backup PowerPoint Presentation*

- ***www.chnet-works.ca***

Step #2 : Teleconference

All Audio by telephone

- If your line is 'bad' – hang up and call back in
- Participant lines muted
- Recording announcement

Step #3: The Internet Conference *(via 'ADOBE CONNECT')*

From our computer to yours

No audio via internet

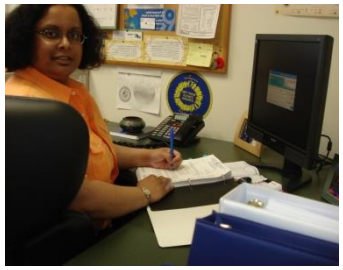
A transmission delay of 1-2 seconds is normal

Difficulties? Firewalls - slow reception, disconnection :

Use the Backup PowerPoint Presentation (Instruction Step #1)

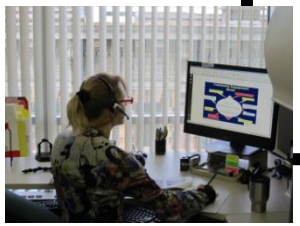
For assistance: animateur@chnet-works.ca

How to post comments/questions during the Fireside Chat



Joining in by
Telephone +
Adobe Connect Internet Conference

Use the text box!



Please introduce yourself!

- ***Name***
- ***Organization***
- ***Location***

- ***Group in Attendance?***

Joining by
Telephone +
Backup PowerPoint
By email:
Respond to the 'access instructions email
animateur@chnet-works.ca

Challenging Health System Leaders to Align Optimal Scopes of Practice and Innovative Care Models to Enable Health System Transformation in Canada: *The Role of Economic Factors*

Presented by:

Gillian Mulvale,

Assistant Professor, Health Policy and Management,
McMaster University

June 19, 2014

RCRHS
Réseau canadien sur les ressources humaines en santé

CHHRN
Canadian Health Human Resources Network

Why look at health professional scopes of practice?

- Health professional scopes of practice and associated models of care tend to be organized on the basis of ***tradition*** and ***politics*** rather than in relation to the evidence of how best to meet contemporary population health needs.
- Elements in our health care 'system' were largely created to respond to acute, episodic care provided in hospitals and by individual physicians.
  - Over the decades, these elements have become ***enshrined in legislative, regulatory, and financial schemes*** that challenge adaptation to shifts in population health care needs.

Balancing Stability and Reform

- While the current institutionalization of scopes of practice has ***shielded the system from radical reform***, there has been incremental change across micro, meso, and macro levels.
- These have included:
  - the development of ***new roles***, such as patient navigators and pharmacy technicians, and
  - the ***expansion of scopes of practice*** for professions such as nurse practitioners and pharmacists

  to address specific populations with higher needs or access issues.

Work Arounds and Scaleability

- But, health care organizations and personnel seeking innovative solutions must often ***work around structural barriers*** in order to optimize resources and improve quality of care.
  - These models typically remain localized and lack systemic supports enabling broader scalability.
  - Unless designed to be integrated into health system transformation at the outset, many of these changes to health professional scopes of practice and models of care end up ***coexisting in parallel*** to mainstream practice

Research Objectives

- The Canadian Academy of Health Sciences (CAHS) charged an Expert Panel in partnership with CHHRN to address the following question:

What are the scopes of practice that will be most effective to support innovative models of care for a transformed health care system to serve all Canadians?

Approach

- To systematically approach the question, the co-Chairs and CHHRN Project Team:
  1. Developed a guiding conceptual framework of macro, meso and micro influences on scopes of practice;
  2. Extracted findings from 125 sources of literature on scopes of practice interventions to see their impact;
  3. Interviewed 50 Canadian and international experts in the field, and
  4. Worked closely with the Expert Panel over an 18 month period to discuss the key findings and generate recommended actions.

CONCEPTUAL FRAMEWORK:

SCOPES OF PRACTICE THAT SUPPORT INNOVATIVE MODELS OF CARE THAT BETTER ADDRESS POPULATION HEALTH NEEDS AND A TRANSFORMED HEALTH CARE SYSTEM

Where we are

Current Canadian Health Care System characterized by insufficiencies around:

Accessibility –particularly for marginalized and disadvantaged populations

Care provided outside of business hours

Wait times

Health promotion including patient involvement and self-management

Appropriate use of healthcare providers and resources

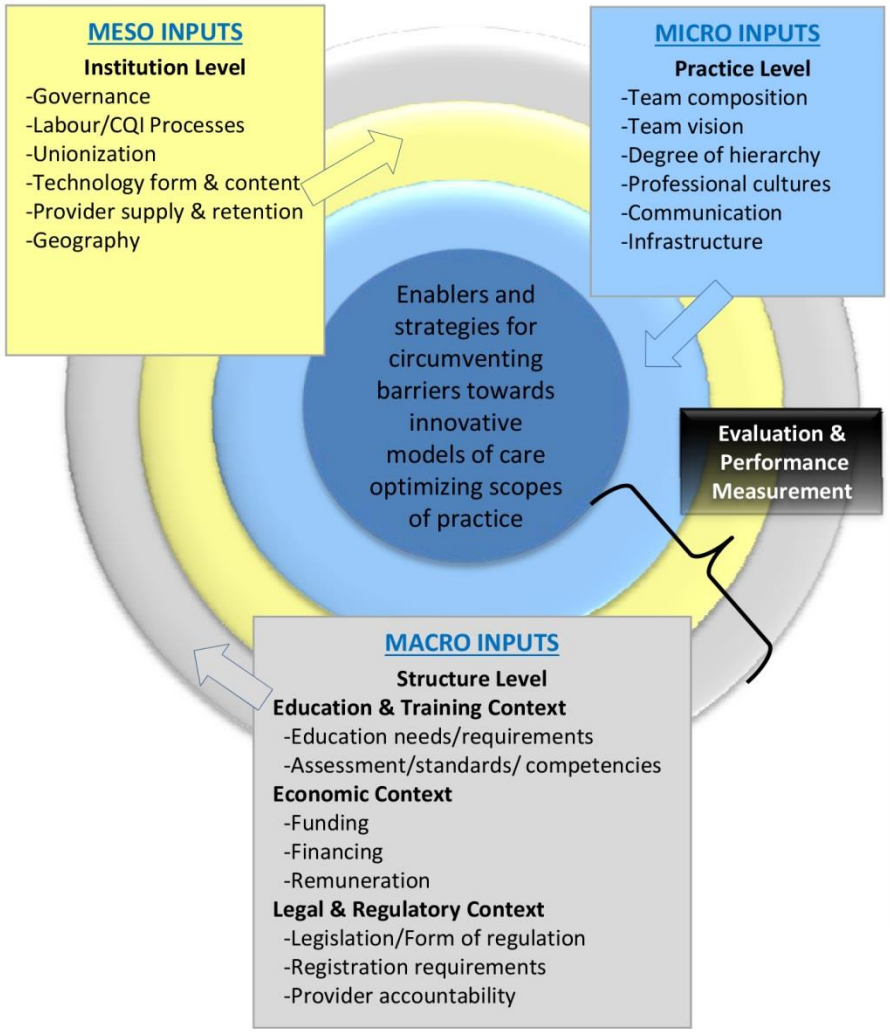
Chronic care management

Mental health care

Elderly and end-of-life care

Fiscal effectiveness and sustainability

How we can get there



Where we want to be

A transformed health care system characterized by:

- A move from supply to need focused (needs determine models to scopes)
- A move from professional to patient focused
- A move from isolated, siloed professionals to teams based on non-conventional and conventional providers
- A move away from historic long term credential SoP to a model of team defined tasks to meet population needs; team allocates resources and responsibilities (task certification process to ensure competency)
- Individual regulation to combined/team accreditation
- Funding groups rather than individuals *(not necessarily health outcomes – process outcomes, reduction to ER)*
- Performance monitoring and evaluation that is aligned with these principles

- *List of insufficiencies from: Nasmith L., Ballem P., Baxter R., Bergman H., Colin-Thomé D., Herbert C., Keating N., Lessard R., Lyons R., McMurchy D., Ratner P., Rosenbaum P., Tamblyn R., Wagner E., & Zimmerman B. (2010). Transforming care for Canadians with chronic health conditions: Put people first, expect the best, manage for results. Ottawa, ON, Canada: Canadian Academy of Health Sciences.*

Scopes of Practice Terminology

- The term ‘scopes of practice’ can encompass a range of professional parameters
  - It has legal, social, and practical dimensions
- A profession’s scope of practice encompasses the activities its practitioners are **educated and authorized to perform**. The overall scope of practice for the profession sets the **outer limits of practice** for all practitioners.
  - actual scope of practice influenced by the settings in which they practice, the requirements of the employer and the needs of their patients or clients. (CNA 2011)

Meanings of Scopes of Practice

- HPRAC's review of health professional scopes of practice extrapolated the following layers:
  - *How professionals **are defined** – who can call themselves a member of the profession…;*
  - *What professionals are **trained to do**;*
  - *What professionals are **authorized to do** by legislation;*
  - *What professionals **actually do**;*
  - ***How a professional does** what he/she does …; [and]*
  - ***What others expect** a profession can do (i.e. delegation).(HPRAC, 2007 p. 2-3)*

Expanded Scopes and New Roles

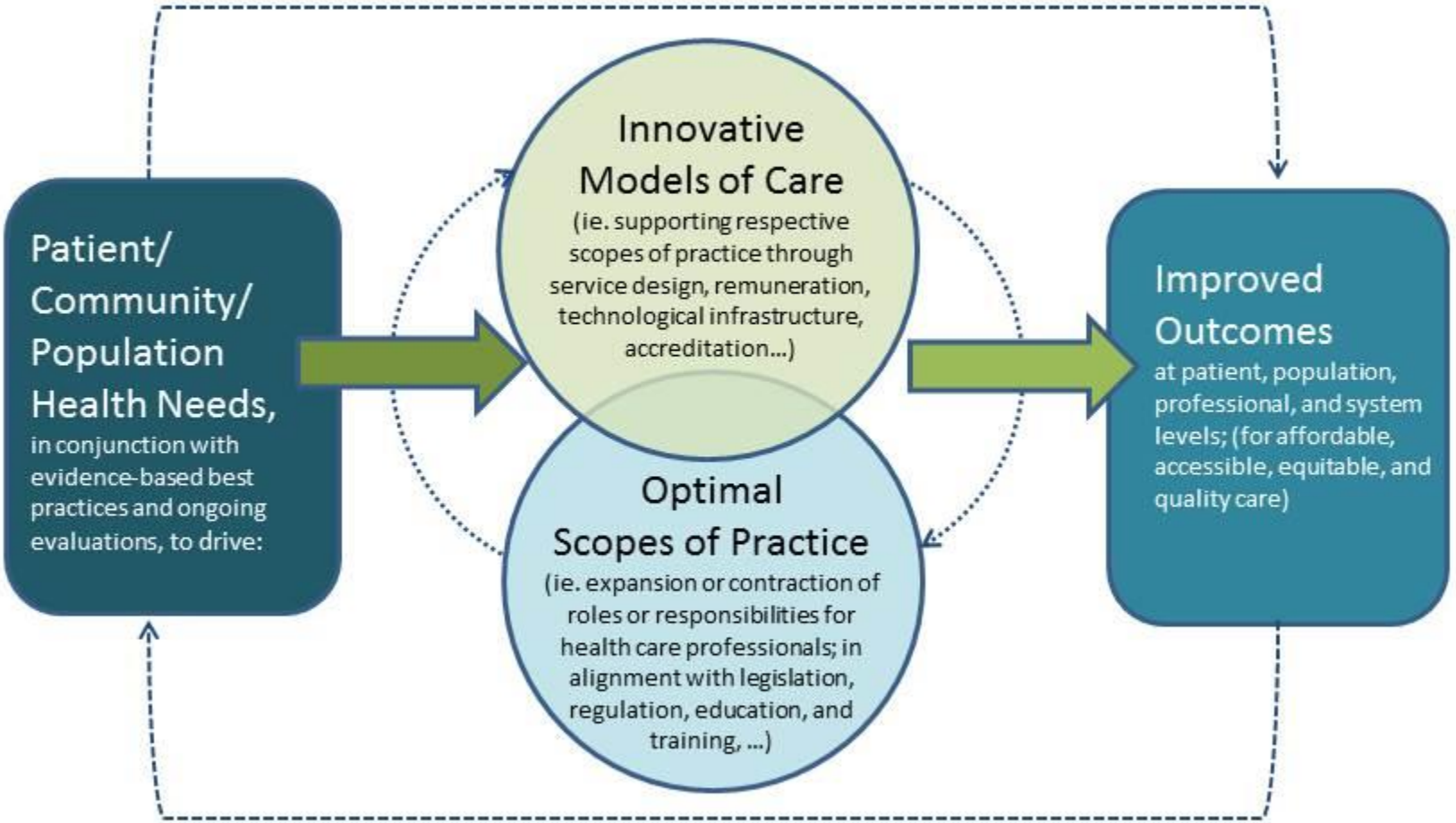
- **Expanded scopes of practice** occur when health care professionals take on a wider range of tasks in the practice setting outside their 'traditional' scopes of practice.
  - may involve the process of **task-shifting**, or delegation of tasks from the responsibility of one health care professional or group to another.
- **New roles** have come into practice that tend to be specific to a setting or institution and have not been adopted across multiple jurisdictions.
  - e.g., pharmacy technicians and patient navigators.
  - Require negotiation around their associated scopes of practice relative to the scopes of practice of existing health care personnel.

‘Full’ vs. ‘Optimal’ Scope

- **‘Full scope’** denotes health care professionals practicing the full range of skills for which they have been trained and are competent to perform.
  - The principle of all health care professionals practicing to their full scope in all contexts may in fact work against the creation of a more efficient, cost-effective health care system.
- **‘Optimal scope’** means achieving the most effective configuration of professional roles, determined by other health care professionals’ relative competencies.

How do Models of Care relate to Scopes of Practice ?

Innovative models for health care delivery are typically seeking to optimize health human resources through decreasing reliance on independent physician services while increasing the role of non-physician health care professionals. Changes to the organization of health care need be reflected in the legislative, regulatory, educational, and training parameters of the respective scopes of practice.



How do Scopes of Practice relate to Models of Care?

Expanding scopes of practice (ie. pharmacists' ability to prescribe), overlapping scopes of practice (ie. nurse practitioners working with family physicians) , and new roles (ie. associated with technological innovations), necessitate modifications to the design and delivery of health care services.

Key Research Finding

- An emerging consensus developed that optimizing scopes of practice, paired with evolving models of shared care can provide a multidimensional approach to **shift the health care system** from being characteristically siloed to one that is collaborative and patient-focused.
- Here we discuss the **economic factors** that act as barriers and enablers related to optimal scopes of practice using the macro (structural) level.

Questions for Audience

- Before we get into the results, to what extent do you think optimizing scopes of practice can be a lever for health systems transformation?
  - Scale here in terms of extent of agreement for responses.
- How important would you think economic factors would be?
- Scale here in terms of extent of agreement for responses.
- What other factors do you think would be important?
- Open-ended

FINDINGS from:

- **LITERATURE, KEY INFORMANT INTERVIEWS**

Themes from the literature

Five of 125 articles reviewed described economic interventions introduced in association with a change in professional scopes of practice

- Types of interventions:
  - Funding to health care organizations or institutions
  - Remuneration of health professionals by government or region
- Focus is on economic factors as 'inputs' in supporting changes in scopes of practice.

Direct/Indirect Effects across levels

Macro:

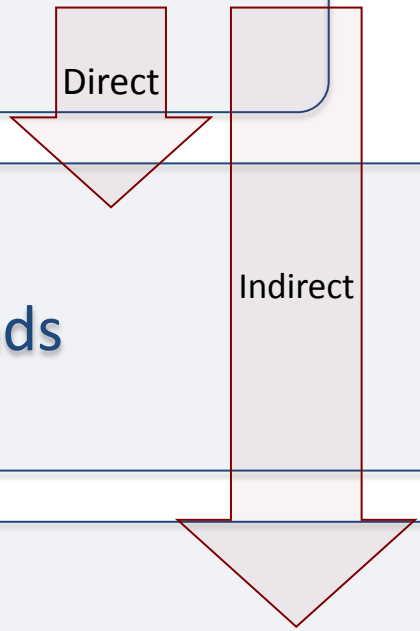
– Direct: change in flow of funds to region

Meso:

– Indirect: Health Authority allocates funds to delivery sites across region

Micro:

– impact on delivery associated with changes in scopes of practice



Economic interventions associated with changes to scopes of practice

Study	Factor	Description
Aziz,2005	Move from FFS to block funding	• Multidisciplinary neonatal resuscitation team • Funding essential to enable inclusion of other professionals
HCC-Nova Scotia, 2009	Additional Funding through private partnership, respiratory/ambulatory care and public health	• multidisciplinary primary health care team: ▪ mental health worker, addiction counsellor, nutritionist, nurses, NPs, SWs, psychiatry, family physicians, community volunteers ▪ Management and administration team

Economic interventions associated with changes to scopes of practice (2)

Study	Factor	Description
Marra, 2012	'Adaptation fee' applied to dispensing fees	• Introduced in conjunction with expanded scope of practice for pharmacists in B.C • Reflects expansion in pharmacists' scope to prescribe medication • Financial incentive to improve drug management
Legault, 2012	FFS changed to capitation	• Supported the development of an anticipatory and preventative care team • NPs, pharmacists paid by salary
Kates, 2002	Physician payment through capitation; program funding	• A mental health care and nutrition team involving family physicians, counsellors, and psychiatrists working in a primary care setting

Summary from the Literature

- Facilitators of expanded scopes of practice and collaborative care models:
  - Alternative remuneration schemes for physicians
  - Additional funding
- Organizational and technological inputs also needed:
  - Supportive political, policy and regulatory changes
  - Supportive hospital by-laws
  - Legal environment changes
  - HR policies (recruitment, training)
  - Realistic expectations for time to change
  - Administrative support

Questions to the Audience

- To what extent do you agree with the findings from the literature
  - Can do a scale here where they score.
- What is missing based on the literature review results? (open-ended)
- Are you aware of other literature? (open-ended)

Themes from Key Informant Interviews

Funding, Remuneration

Silos in Funding

- restricts opportunities for interprofessional collaboration

"I find this question that you're posing to be about the most frustrating in all of Canadian health care policy. We have all of the tools available to us, with one exception, and that is that if I were to do anything, it would be to move physicians inside the tent [i.e., to include them in the same funding envelope as other health professionals] …. and that to me is the thing that absolutely has to change before anything else can happen."

FFS Remuneration

- Significant barrier to collaboration
  - both a funding and payment model for physicians
- *"With fee-for-service, the fee is only paid if the service is provided by a physician. Even a well-intentioned practice won't hire an allied health care professional to do the work because it's a cost to the practice with no associated revenue stream."*

Alternate payment schemes

- Non-FFS physician payment is necessary, but insufficient condition.

"... If the practice is funded through capitation, salary, or global funding they are provided with money to meet the needs of the population and will hire the appropriate mix of health care professionals to do so."

Population-based Funding

- *"…best evidence out there for success, if you're talking about innovative practices and use of [health human resources] efficiently, it's the closed systems that have any hope of doing it… it's this defined population, responsibility for a set population, and responsibility for the continuum of care."*

- enables innovation over time to optimize scopes of practice.

Bundled Payments

"If you think about surgical models that are innovating in Alberta, we've seen a few that are using physician extenders and more coordinated in-take. … And the main innovation there seems to be that you've got alternative payment that it isn't so linked to who's doing each particular step of the care pathway. They're paying more from entry to exit through the entire pathway."

Needs-based Payment

- Rather than tying remuneration to provider or setting, tie it to population needs

- *"Start thinking about recommendations of payments for services that people need rather than services provided by a particular group in a particular place…physicians and centres leveraging private sources of funding which tend to be less specific about who provides the service and what for. Like think of the most generic form of a flexible spending account."*

Other Themes

- Economic Incentives alone are not enough, need fundamental change to the structure of the system
- Some suggest linking financial incentives to performance measures
  - But concerns about gaming and motivations with pay-for-performance systems
  - Can only work if measurable
- Tailor financial incentives to type of patients

"…some patients are much sicker and need a lot more care. Other patients don't. And the model that will work for a relatively healthy population may not be the same as the model that will work for a sick population."

Extrinsic vs. Intrinsic Motivation

"Money is an extrinsic driver. Doing a good job, having pride in your work, wanting to produce something better today than you produced yesterday, that's intrinsic drive and motivation. And it turns out that all the research and every industry that's ever looked at this, the places that are really successful and drive outstanding performance over time figure out how to tap into people's pride and intrinsic drivers…

…as soon as you start to try to put in place, you know, checklists that add up to certain scores that then get you bonuses, or you withhold pay…you're trying to meet the requirements to get the money to which you think you are already deserving. And that de-professionalizes people."

Questions to Audience

- To what extent do the findings of the key informant interviews resonate with your experience in each area:
  - Funding
  - Insert scale of agreement here
  - Payment
  - Insert scale of agreement here
- Is anything missing in terms of economic considerations not captured here? [open ended]

Take Home Messages

- Economic factors are not enough to change structure of delivery in health system, but may facilitate along with changes in other factors.
- Alternative remuneration schemes seen to be a key enabler
- Be careful your incentives don't 'get in the way'
- Lack of funding stability a barrier
- No perfect model for all situations, must be adapted to health of population and other specific circumstances

Recommendations

- **Provincial/Territorial Governments:**
  - Adopt alternative funding structures to support collaborative practice among professionals within and across settings.
  - Initiate a review of professional and union collective agreements to examine their impact on flexibility in health professional scopes of practice.

Questions for discussion

- **What more needs to be done** with regard to economic factors? Is there anything missing?
- **What can you do within your domain** that can aid in optimizing scopes of practice?
- **What are the workarounds** that you have found effective in terms of economic barriers?
- **Are there economic facilitators** that you can point to from your experience?