14th International Health Workforce Collaborative

Making health workforce innovation real.

Authors

Lord, N[a]; Scheepers, E[b]; Groulx, A[c]; Mertz, E[d] ; Mahill, M[e].

Introduction

Innovation in service delivery and organisation has been defined as a novel set of behaviours, routines and ways of working that is directed at improving health outcomes, administrative efficiency, cost effectiveness or users experience.[1] Factors in innovation may include processes involving diffusion, dissemination, implementation and sustainability of something new or different. Innovation in the health workforce often starts with an individual or small group of individuals responding to a locally identified need in their health service. Most jurisdictions grapple with how these good ideas and small scale projects can be translated into large scale changes that can bring benefits across a large healthcare system. This session explores the policy, practice, implementation and research factors needed to successfully drive health workforce innovation on a large scale.

Session objectives

- To explore the elements of health workforce innovation in practice.
- To examine factors for diffusion of innovation from a small or localised environment.
- To consider the measures for success of innovation.

Session approach

A *world café* approach will be utilized for this session. After a brief introduction from the session moderator, this session will break into four discussion tables. At each discussion table, a brief case study of a workforce innovation will be given by a nominated presenter. The workforce innovation may be at different points of adoption, diffusion, dissemination, implementation or sustainability. Time will be given for a presentation and discussion of key questions by the table.

At the conclusion of all presentations, the plenary session will be re-convened and each presenter will report back on the project and the discussions of key success factors that occurred at each discussion table. Time will be provided for discussion and questions from the floor.

A summary of presentations is provided on the following pages, to allow participants the opportunity to orientate to each innovation prior to the presentation.

[a, b] Workforce Innovation and Reform, Health Workforce Australia

c Ministry of Health and Social services, Province of Quebec, Canada

d San Francisco School of Dentistry, University of California

e Centre for Workforce Intelligence, United Kingdom

1 Greenhalgh, T.,Robert, G. et al (2004). Diffusion of Innovations in Service Organisations : Systematic Review and Recommendations. The Milbank Quarterly, 82(4) :581-629.

Presentation 1.

Quebec's medical home: Family Medicine Groups.

Presenter

Doctor Antoine Groulx
Director
Primary healthcare services
Ministry of Health and Social services, Province of Quebec, Canada

Background

Stemming from recommendations of the Clair commission (2002) - an evaluation of health and social services in the province of Quebec - Family medicine groups were established in 2002. According to the commission's main statement, a primary care model was needed to address common health care issues experienced in the province, which led to the implementation of the Family medicine group, a model designed to (1) improve access to health care, (2) ensure appropriate follow-up and coordination of patient's lifelong care, (3) promote preventive care, (4) encourage effective dissemination of clinical and administrative information and (5) link the province's network of social health centres (CLSC) more closely to physicians.

Summary of the innovation

The Family Medicine Group model innovated on a variety of fronts. For one, this model was the first in Quebec to gather family physicians and create a formal and functional collection of health professionals that collaborate together on a daily basis. This model thereby encourages physicians from different settings to come together and share their expertise. In addition, this model promotes inter-professional collaboration as it involves the direct participation of nurses.

Another element that underlines the model's innovative features can be observed in that it encourages a formal connection between the local social health centre (CLSC) and the Family Medicine Group using various modalities.

Outcomes of the innovation

Ten years after its implementation, the model has expanded into 250 Family Medicine Groups. Their broad development has brought us to make quite a few discoveries on the model, elements that deserve our attention. In this context, the Ministry of Health is currently tweaking the model in order to reflect the variety of realities in which they must develop.

Future directions of the innovation

The Ministry of Health is currently working on improving the model and adapting its modalities. New features will include incremental funding and the development of outcome indicators, such as a loyalty indicator, which will capture patterns of patient consultations and help us determine to what extent each family medicine group has the ability to provide adequate access to its registered patients.

Presentation 2.

Dental Therapy: Importing Workforce Innovation in the US Context.

Presenter

Elizabeth Mertz, PhD, MA
Assistant Professor in Residence
Preventive and Restorative Dental Sciences
Center for the Health Professions
University of California, San Francisco School of Dentistry

Background

The US has struggled with low accessibility of dental care for many populations (i.e. elderly, low income, disabled, institutionalized), with as much as 1/3 of the US population estimated unable to get care[1]. The 2000 US Surgeon General's report on Oral Health noted workforce deficits and called for improved workforce diversity, capacity and flexibility[2]. Until this time, the US state-based system of regulation of dental care, with regulatory boards dominated by dentists, had limited dental hygienists and assistants from expanding their scopes of practice. This trend began to change in the 2000s as dental hygienists made gains in liberalizing practice acts,[3] and as public health advocates frustrated with the lack of progress in addressing the access issue, began efforts to introduce dental therapists into the US dental workforce. [4]

Dental therapy (DT) is now a program of study and practice in 54 countries and has been in existence for 92 years.[5] DTs are being promoted as a cost-effective way to expand access to primary dental care within the US, particularly with underserved populations.

Summary of the innovation

In 2001, an initial proposal to the Robert Wood Johnson Foundation was submitted to pilot dental therapy within the US Indian Health Service. While RWJF did not pursue this, funding for the project was secured from the Alaska Native Tribal Health Consortium (ANTHC).[6] In 2003, six students from Alaska were sent to New Zealand to be trained in the Dental Therapy Program. This was followed by a high profile court case where the American Dental Association and the Alaska Dental Association sued ANTHC claiming DTs would violate the Alaska's dental practice act. The courts ruled in favor of ANTCH due to the fact that these organizations did not have jurisdiction over tribal health. In 2005 the new DTs returned from their training and started working in in ANTCH, as dental health aide therapists (DHATs). In

[1] Brown LJ. Adequacy of current and future dental workforce: theory and analysis. Chicago: American Dental Association; 2005.
[2] U.S. Department of Health and Human Services (2000). Oral health in America: a report of the Surgeon General. Rockville, MD, U.S. Department of Health and Human Services.
[3] See http://www.adha.org/legislative-tracking
[4] Gehshan, S., M. Tackach, et al. (2009). Help wanted: a policy maker's guide to new dental providers. Washington DC, National Academy for State Health Policy, W.K. Kellogg Foundation and the Pew Charitable Trusts.
[5] Nash, D. A., J. W. Friedman, et al. (2012). A review of the global literature on dental therapists, W.K. Kellogg Foundation.
[6] Nash, D. A., J. W. Friedman, et al. (2012). A review of the global literature on dental therapists, W.K. Kellogg Foundation.

2007, the University of Washington opened up the first dental therapy training program in the United States, allowing Alaska Natives to be trained in the US.
Following this battle, two major health foundations, the Pew Charitable Trusts, Center on the States, and in the W.K.Kellogg Foundation, launched major workforce campaigns to expand the dental workforce through such initiatives as dental therapists. [1] In 2009 the state of Minnesota authorized the training and practice of two levels of dental therapists, the Dental Therapist (DT) and Advanced Dental Therapist (ADT). Licensed providers of both sorts are now in practice.

Outcomes of the innovation

The DT movement in the US is quite controversial, but is gaining ground. To date, three different types of providers (DHAT, DT and ADT) now are in practice across two states, with several additional states pursuing training and licensure of DTs. The original introduction, the DHAT in Alaska, has undergone several evaluations, all of which have been positive. [2,3] The Minnesota Dental Therapists are being widely studied, and to date preliminary evidence has been positive.
The organizations that are employing dental therapists outside of Alaska (where they are solely employed in ANTHC) for the most part are large group or integrated practices, or non-profit dental care groups. If improvements in access and reductions in cost are shown to exist while quality is maintained, it is likely that this innovation will be further adopted by US states.

Future directions of the innovation

Spread of the practice will be contingent on several factors:

- Further state legislative adoption and incorporation into practice acts. Additional states, including Ohio, Oregon, Kansas New Mexico, Vermont, Washington, California, New Hampshire and Maine have, or are considering, approving DT practice.
- Ability to sustain movement momentum - currently efforts involve grass roots advocacy and high level foundation support
- Training program availability (including accreditation). CODA, the organization which currently accredits all dental education has been reluctant to move forward with an accreditation process, but other groups are developing standardized curricula and competency areas. The key issues is the level of the education, DHAT[4]s are educated post-high school, while the DT is a Bachelor's or Master's degree[5] and ADT is a Master's degree[6].
- Payment reform – both general dental insurance coverage of underserved populations and ability to pay DTs as providers under these programs.

[1] Edelstein, B. L. (2009). Training New Dental Health Providers in the U.S., Columbia University and Children's Dental Health Project: 50 and Gehshan, S., M. Tackach, et al. (2009). Help wanted: a policy maker's guide to new dental providers. Washington DC, National Academy for State Health Policy, W.K. Kellogg Foundation and the Pew Charitable Trusts.
[2] Bolin, 2008a
[3] Wetterhall et al, 2010.
[4] http://depts.washington.edu/dentexak/dentex-program/
[5] http://www.dentistry.umn.edu/programs-admissions/dental-therapy/index.htm
[6] http://www.metrostate.edu/msweb/explore/gradstudies/masters/msadt/

Presentation 3.

Workforce planning along care pathways

Presenter

Meena Mahil
Head of horizon scanning and care pathways
Centre for Workforce Intelligence (CfWI)

Background

It is widely accepted that integration is key to delivering more effective and efficient care and that the workforce will play a huge role in achieving this goal. Although improvements in the quality of service planning have been made over the last few years, workforce planning for health and social care continues to be challenging. Care pathways are commonly used for service delivery planning in the NHS but this planning is rarely completed alongside workforce planning. The traditional care pathway approaches keep people who use services at the centre of the journey but generally do not take the skills, competencies and requirements of the workforce into consideration.

Summary of the innovation

The CfWI care pathways toolkit is designed to guide users through a methodology for workforce planning along a care pathway. It can sit alongside integrated pathway development, or be used to analyse and improve the current workforce structure. The toolkit adds a robust workforce planning component to pathway redesign, and aims to encourage integrated workforce planning between different organisations. This should result in patients and people who use services receiving a more joined-up service from those delivering their care.

We have designed the toolkit to be used by anyone responsible for local-level workforce planning. By working through the stages of the toolkit, users will obtain detailed information about:

- the key activities that need to take place for a person to move along the care pathway
- who is currently carrying out these activities
- the skills needed to carry out these activities effectively
- bottlenecks in the pathway, and the workforce reasons behind them, e.g. skills gaps.

This information feeds into an analysis of the workforce, which allows toolkit users to explore different scenarios for how the existing workforce could be used. Based on this analysis, and their local needs, users can make decisions about how to deploy the workforce to deliver the best outcomes for patients and people who use services in a cost-effective way.

The toolkit provides a structured and systematic approach to analysing care pathways in terms of the workforce. There are several benefits that can be realised by following this approach. For example, the toolkit can help to:

- identify current/potential bottlenecks
- improve understanding of what is needed to deliver the pathways
- investigate different workforce and pathway scenarios
- make better use of the workforce and other resources
- support service redesign to improve outcomes and potentially release cost savings

- integrate health and social care services.

The toolkit was trailed on an integrated discharge care pathway in two local health economies covering acute, community and social care organisations. In these organisations, the toolkit was used to identify, analyse and propose an effective solution to workforce-related bottlenecks along a care pathway. In one area, the toolkit identified a recurring workforce saving by revising the role of one resource. The full potential of the toolkit has not yet been realised, although it is clear that there are opportunities to identify further savings by following the approach.

Future directions of the innovation

The toolkit is currently available for use by any organisation online and can be accessed at: www.cfwi.org.uk/care-pathways. The toolkit has also recently been used in the CfWI maternity project. The project is aiming to create a focused workforce modelling tool that is specifically relevant to a nationally defined maternity care pathway. The maternity care pathway workforce model aims to work with providers to produce a modelling tool to support individual maternity services to analyse their whole workforce (not just midwives) as part of any service redesign in order to meet future demand.

We are currently undergoing an extended evaluation period, lasting until summer 2013, during which we will be measuring uptake and soliciting feedback on the toolkit. We will then review the toolkit once more and make improvements as necessary. We are also exploring the possibility of modelling skills and competencies using our systems dynamics framework.

Presentation 4.

Health Professionals Prescribing Pathway - a national approach to prescribing for the Australian health workforce.

Presenter

Nicholas Lord
Program Manager, Workforce Innovation and Reform
Health Workforce Australia

Background

Australia is among numerous first world countries (including the United States of America, New Zealand, Canada and United Kingdom) to introduce limited forms of prescribing by non-medical health professionals.[1] The Australian experience of prescribing by non-medical health professionals has been mixed.

Health professions have sought to adopt prescribing within their scope of practice with few established reference points or requirements beyond their own profession. The education sector has sought to adopt and integrate prescribing education and training to health professionals without reference to a recognised inter-disciplinary standard of education or process that assures the quality of prescribing education. State and territory jurisdictions, having responsibility to legally authorise health professionals to prescribe medicines, have experimented and implemented ad-hoc for non-medical prescribing, which may support localised need but introduce barriers to mobility and flexibility in the workforce.

Summary of the innovation

The aim of the project was to develop a nationally consistent enabling approach to prescribing by health professionals other than doctors. Key topics within this approach were identified early in the project as being:

- Consistent prescribing education and training to a nationally recognized standard.
- A national approach to recognising the competence of a health professional to prescribe.
- Developing safe models of prescribing practice, supported by appropriate local and jurisdictional governance processes.
- Ensuring an appropriate system of maintaining and enhancing the practitioner competence of a health professional to prescribe.

The Health Professionals Prescribing Pathway describes:

- The steps that a health professional must complete in order to safely and competently prescribe.

[1] Bhanbro S, Drennan VM, Grant R, Harris R. (2011) Assessing the contribution of prescribing in primary care by nurses and professionals allied to medicine: a systematic review of literature. *BMC Health Services Research* 2011; 11:330

- The safety and quality requirements that support each of the pathway steps.
- The roles and responsibilities of all stakeholders in the prescribing process.
- Prescribing models that support safe practice.

Outcomes of the innovation

In January 2013, HWA released a draft HPPP for feedback from stakeholders. The consultation period closed in March 2013, and the final HPPP has been prepared for government consideration, along with recommendations for national implementation.

In addition, the development of a prescribing pathway has strong support from Australian consumers, with a qualitative survey of 1,033 consumers reporting that 81% support the development of non medical prescribing provided appropriate safeguards are in place.[11]

Future directions of the innovation

Future work to support, adopt and implement the HPPP is proposed to include:

- Diffusion of an established prescribing competency framework as a standard for prescribing education for health professionals.
- Development of consistent standards for recognition of competence by health professional boards and accreditation councils.
- National mechanisms to confer authorisation to prescribe.
- Support for current initiatives in communication and information support, including electronic health records.

[1] Health Workforce Australia (2012). Consumer narrative survey on prescribing experiences. www.hwa.gov.au/sites/uploads/Attachment-C-Consumer-Narrative-Survey-Report.pdf