Toward Interdisciplinary Team Development:

A Policy Paper of the National Academies of Practice

Contents

Introduction

The National Academies of Practice (NAP) is an interdisciplinary nonprofit organization with membership representing ten health care professions. Members must be distinguished practitioners in their field and are elected to this honorary by vote of all disciplines. The NAP mission is to serve as distinguished advisors to health care policy makers in Congress and elsewhere. Since our founding in 1981, NAP has produced a series of public policy papers on various aspects of health care reform. Most recently, these policy papers have focused on access to health care, prevention issues and interdisciplinary healthcare. More information about NAP, including current policy papers, can be found at our website: www.NAPractice.org.

NAP is committed to the concept of interdisciplinary/interprofessional practice and is concerned about the lack of progress in achieving this goal in this country. Achieving widespread interprofessional practice is critical to the success of healthcare reform. In developing the background and our conclusions about the steps needed, NAP relied on two primary sources of information: a review of pertinent peer-reviewed publications and a Forum hosted by NAP in Arlington, VA on March 26, 2011. The Forum, "Achieving Interdisciplinary Care," included collaborative discussions among NAP members and guests and presentations by six nationally known speakers. The Forum speakers were:

Mary Wakefield. RN, PhD, Administrator, HRSA, US Department of HHS
: Dr. Wakefield provided an overview of programs planned and in progress that would forward the development of healthcare teamwork.

Heather Boon, BScPharm, PharmD, Associate Professor of Pharmacy, University of Toronto
: Dr. Boon provided us with an analysis of the different levels and types of teamwork and integrated care.

Eduardo Sanchez, MD, MPH Vice President, Chief Medical Officer, Blue Cross/Blue Shield of Texas
: Dr. Sanchez discussed the variety of financial packages available to practitioners in different settings.

Jean Yudin, MSN, RN, CS, Director and Nurse Practitioner, University of PA Health System
: and
Jeanette Gallagher, MSW, Institute of Aging, University of PA Health System
: Ms. Yudin and Ms. Gallagher presented evidence of how a true interdisciplinary team functioned providing home care to the elderly.

Madeline Schmitt, RN, PhD, Professor of Nursing Emerita, University of Rochester
: Dr. Schmidt reviewed national and international programs and progress in interdisciplinary education.

NAP believes that in order to achieve successful healthcare reform, America's current health care system must move toward a more robust infrastructure of primary care and home and community-based services, move away from fragmentation to care coordination and focus on process as well as outcome accountability for patient care results.

NAP Recommendations

NAP calls upon CMS and HRSA to make use of their current authority to:

1. Institute pilots, demonstrations and funded grant initiatives to take health reform to the next level, testing new models of health workforce delivery, including interdisciplinary/interprofessional teams.

2. Address new conceptual models for healthcare delivery that will assist solo and small practices to transform to a team model to treat the whole person.

3. Expand conceptual models for integrated healthcare delivery to include non-physician practitioners (e.g. dentists, nurses, pharmacists, psychologists, podiatrists, social workers) as primary providers.

4. Promote and support interprofessional guidelines.

5. Promote and support interprofessional education at pre- and post-doctoral and community levels.

I. Background

Interdisciplinary Teams and Healthcare Reform

A. What does "interdisciplinary/Interprofessional team" mean?

'Interdisciplinary' or 'interprofessional' are terms meaning more than one discipline or profession. 'Team' implies at least two people working together in some fashion. But how they work together may take many forms. Boon describes 7 levels of 'team' functioning[1].

1. independent healthcare practitioners: work in a common setting
2. consultative team: traditional medical referral model
3. collaborative team: independent practitioners sharing information
4. **coordinated team**: a formalized structure in which members share records and communicate about specific patients
5. **multidisciplinary team**: multiple different disciplines, each practitioner making independent decisions, with a team leader appointed to integrate the various decisions
6. **interdisciplinary team:** multidisciplinary group that makes group decisions, usually based on a consensus model, face-to-face meetings common
7. integrative care team: non-hierarchical blending of conventional medicine and complementary and alternative healthcare

For the purposes of this paper, we will use 'interprofessional/interdisciplinary team' to include the highest levels of teamwork: coordinated, multidisciplinary and/or interdisciplinary teams.

B. Healthcare reform and the interdisciplinary team

The current health care enterprise is incapable of using the flood of new knowledge or meeting the needs of the increasing proportion of the population with complex medical needs[2] . The costs of the institution/procedure-dominant fragmented system are unsustainable as well as ineffective. **Change in the delivery system is both required and inevitable.**

Change is needed and new structural models – medical homes[3], ACOs, home-based primary care – are being studied and supported. However, it is important that we realize that we do not now have the medical workforce resources necessary to fully operate in these "old" models. New workforce resources could be brought into play by expanding roles of many health professions now peripheral to the physician-dominant delivery models. Expanding the workforce and rethinking what additional "homes" might be appropriate are avenues for growth and improvement in healthcare delivery.

In addition to expanding the healthcare workforce, the newer delivery models are emphasizing teamwork. We agree that integrated teamwork will better serve the patient rather than the fragmented care that is currently standard. Moving to effectively led teams can and should be tomorrow's delivery model. But many health practitioners operate in solo or small practices. Indeed, nearly half of physician-based health care delivered in this country is provided by solo or small group physician only practices[4]. But other practitioners are also mostly solo

or single professional small group based – psychologists, dentists, podiatrists, social workers and so on. Current federal planning has missed an opportunity to assist these practitioners to form integrated care teams.

C. Specifically, what do current healthcare delivery change plans lack?

1. The existing authorities of CMS and HRSA will test the relationship between several specific structures and outcomes (group practice, medical home, etc.). But they should also test a much wider variety of models of health professional teams in a wider base of health problems, ethnic settings, and non-physician practices. The resulting data would be critical in understanding what either contributes to or impedes successful outcomes.

2. Many programs (such as ACOs) or those in the Innovation Center do not specifically stipulate interdisciplinary teams to deliver care. Most of the HRSA grant funded programs in the prevention section do not either. Expanding Federally Qualified Health Center expansion is commendable, but there is no requirement for these to test out new models for health provider usage. By contrast, the Independence at Home demonstration specifically calls for interdisciplinary teams to deliver care.

3. In response to patients, unable to access care due to health workforce shortages, the healthcare "system" has filled the gap with "minute clinics," drug store pharmacists, mall-based optometrists, and others not just for specialty services, but for primary care services. As adjuncts to an integrated health system, these services may be useful but as freestanding services they serve to increase fragmentation. National plans for healthcare reform fail to include plans for regulating the integration of these freestanding services.

4. National health care reform in the United States provides the opportunity when the concept of "interdisciplinary teams" must move from being an interesting idea to a practical necessity. Interprofessional team practice, which is common in geriatrics, home, hospice, rehabilitation, and some aspects of mental health, is rarely found in other areas of health delivery. Teams have the potential to become the cutting edge management tool in private practices, managed care, group practices, integrated health care systems[5].

5. National plans for healthcare reform lack sufficient support and funding to develop a research base that can provide us with enough evidence-based information about the structure and composition of teams that work best to a) advance the health promotion and prevention agenda, b) resolve acute care needs or c) coordinate and manage chronic health issues. Nor does the current research base provide us with information about what teams work best in to varying populations (rural, urban, migrant, ethnic). Nor do we know what kinds of teams work best in different kinds of practice models (solo, group, integrated health plan/health system).

6. National plans provide little funding for interprofessional training at the graduate, post-graduate or practice level. Evidence-based research is sparse at best[6]. Training modules need to be developed, funded and promoted.

II. Background

Past Experience with Interdisciplinary Teams

We can learn from segments of the healthcare delivery systems where teams are used, speeding the learning process for the whole system. Interdisciplinary teams may be novel to many, but they are not new. Several organizations and institutions have made explicit recommendations for expanding education and training for interdisciplinary teamwork. These recommendations are based on evidence that demonstrates that care by such teams can lead to improved health outcomes and lower costs including improved care of common chronic illnesses, better medication adherence, fewer adverse drug reactions, preservation of function, and decreased hospital readmissions[7]. Based on the evidence, interdisciplinary care of the elderly is recommended by the IOM practice as it can lead to positive improvements in health care[7]. However, further studies are still needed[8].

Several studies have reported on what makes for a successful team[9-12]. In 2000, NAP convened a panel to review the literature regarding what elements were needed for successful teamwork. The following is adapted from that article[13].

A. **A governance structure that values interprofessional health care delivery** must be in place because collaboration must occur at all levels of the organization. This includes all direct service providers both within and across agencies. The structure needs to be formal but flexible.

B. **Group decision-making** across different stakeholder groups through an inclusive process is necessary.

C. **Collaboration must be funded** for it to occur either through creation of a pool of new dollars or through team member contribution to a pooled fund.

D. **Personnel decisions must be collaboratively made** with each profession or agency allowing selections to be "vetted" by other members of the team.

E. **Interprofessional education** is necessary about the collaborative processes and needs to involve students at the graduate as well as practitioners at the post-graduate and community levels[14].

F. **Neutral ground** should be used for team meetings to prevent the perception of bias.

G. **Good relationship-building strategies** should be used to develop a collaborative model: starting small, building on strengths, recognizing limitations, nurturing collaboration/building trust, encouraging innovation and risk, ensuring communication and regular meetings; demonstrating patients and persistence;

H. **Involving the patient and family members** to make them part of the team is essential.

I. **Outcomes must be evaluated** and should include satisfaction measures of the population served and their caregivers, maintenance or increase in function as well as cost-effectiveness.

III. Background

What Are the Barriers to Wider Adoption?

Many sources have documented barriers to the development of interprofessional team[6, 9,16.]

A. Leaders in health care delivery – usually doctors – are taught to be "lone wolves" individual healers of their patients, valuing autonomy and/or authoritarian power over others rather than objectively trying to organize care to best meet the needs of patients. **Management skills – leadership, delegation, supervision – are not taught as a general part of the medical curriculum and are not part of the usual culture.** Physician leaders, and other team leaders, need to be taught new skills and how to operate in a new culture[15].

B. **Today's reimbursement system values specialists more than primary care.** It excludes or limits payments to many kinds of health professionals, fails to reimburse for team activity, and reinforces the solo practice model of specialists, rewarding volumes of tests and procedures rather than results. Payments must cover all required activities by all participating professions as well a covering payment for team meetings and communication. Further, accountability for results must increasingly be the basis of payment.

C. Providers generally do not know each other's capabilities, and see discussions of scope of practice as a series of "turf wars" rather than a shared attempt to realize value, use and grow the skills of every member of the healthcare team. Given US demographics, there will not be enough primary care providers in many areas to meet health care demands for many years to come. **Developing understanding and respect for different health professionals that contribute to the care of the whole patient must be cultivated in health care training and in the understanding of the public receiving health care.**

D. **Providers usually refer to each other individually rather than focusing on communication with each other to develop a shared consensus on what is best for the patients, and a multi-part patient care plan**. It is just this kind of shared consensus and care plan development that is needed, especially by individual patients with complex needs. Networks of providers could do the same thing if they chose to and the reimbursement made it possible.

E. Most providers lack the electronic means to evaluate patient data on a shared basis, and the paperwork trail, or lack thereof, often makes communication impossible. Because each location of care is its own silo – the office, the home, the hospital, the nursing home or rehab facility each with its own records, systems of care and limited means of facilitating care transitions; EMR's/EHR's also have to be interoperable. If teams are to work across settings of care – something that is rarely achieved, and is not required even by the new meaningful use legislation – support for bridging electronic communication of health care information among different settings must be a priority. **The meaningful use of electronic medical records integrated into a team approach is absolutely required if providers are to share information most effectively**.

F. The focus of the team is the patient and the patient is the common denominator across all health settings. Patients must be involved in contributing to ER data and in decisions about their care. **Patients' access to their individual EHR and integration of the patient as part of the team is critical**.

G. There is a limited research base reporting evaluated "best practices" for teams. **Questions to be answered include best team usage for – what patients, what clinical issues, what results, what locations?**

H. There is a general lack of interprofessional training and education in spite of recommendations by a 2003 report from the IOM. The report needs to be reread **and financial support for developing effective interprofessional education needs to be forthcoming**[16,17].

IV. Improving Healthcare Reform

What Needs To Be Done to Maximize Impact?

In this country, we lag far behind our neighbors to the north who in 2006 began to develop a blueprint for implementing interprofessional care in Ontario[18]. The authors argued that interprofessional care would lead to increased access to health care, improved outcomes for people with chronic diseases, less tension and conflict among caregivers, better use of clinical resources, easier recruitment of caregivers and lower rates of staff turnover. The authors proposed four building blocks that needed to put in place in order to successfully implement interdisciplinary healthcare reform: building the foundation, sharing the responsibility, implementing systemic enablers and leading sustainable cultural change. The needs for the United States are not so different, although the commitment to move towards interdisciplinary care is much weaker. We propose:

A. The relevant agencies need to agree that **testing interdisciplinary team concepts needs to be a priority,** particularly ones that stretch scarce healthcare resources. Such testing needs to be done at least in one or more demonstrations/programs that focus on helping smaller practices as well as large organizations.

B. The training funds that currently do exist for interdisciplinary centers of excellence (HRSA) need to be tied to the extent feasible to real world practice model demonstrations. This includes innovative ways to train currently practicing physicians through continuing education models, for example. **Funding for interdisciplinary training needs to be expanded both in professional schools and in the practice community.**

C. What is known about interdisciplinary teams in healthcare – for example, how populations or diseases are addressed by different teams or how the team function is altered by locale and patient mix – needs to be widely disseminated, and **a mechanism established for evaluation of results of differing models to provide feedback** to those experimenting with the concepts.

D. **Payment models** also need to be constructed and evaluated such that **fair compensation and incentives for effective team function** and outcomes are present for all members of teams or delivery systems that effectively utilize interprofessional team.

V. Summary

Getting to Interprofessional Practice

- ✓ There must be a substantial increase in and support for interdisciplinary/interprofessional educational programs in graduate schools as well in the community with training of current practitioners in team models.
- ✓ There must be institutional and environmental support through demonstration projects and funding for interdisciplinary/interprofessional team interactions.
- ✓ There must be practice guidelines and protocols to guide the collaboration across professions.
- ✓ There must be support and funding to improve the research base for interprofessional practice and education
- ✓ Teams need to be encouraged to develop across a path from the parallel and consultative, through collaborative, coordinative, and multidisciplinary to an interdisciplinary team. Only then will we achieve the promise of true healthcare reform in America and increased healthy functioning for the whole person.

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