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A Novel and Practical 'Care Process' Framework to Inform Model of Care Development

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"I can't get to what I am trained to do because I'm too busy gathering data about patients and not doing what I was trained to do"
Physiotherapist

"This is the best team I have ever worked with before – it's so important we work closely with the Island Health clinicians as we share many clients in this community" Nu-chal-nulth RN

ABSTRACT

Breaking free of pre-existing assumptions to achieve transformative change in care delivery remains challenging. This article presents a care process framework using a rapid task analysis tested with healthcare teams across five communities in British Columbia, Canada, to provide leaders a novel and practical approach to care model development. The study's goals were to determine if the framework was replicable even though the population care needs differed for each community. The results showed the framework was replicable, informed the care model development, and identified ideal scopes of practice and team composition given the context of care. The framework also captured expert tacit knowledge and decision-making to build capacity given our current workforce challenges. For operational leaders and government agencies, the use of the framework may influence a shift in historical approaches that better aligns health and human resources capacity to population health and service needs.

PROBLEM

There is a lack of practical frameworks and explicit designs of studies in the health sciences literature that inspire leaders to think differently. There is also a need to shift from historical approaches to model of care development to one that is more responsive, flexible, and collaborative, where patient and population health needs drive model of care development and align better to a range of scopes of practices and staff mix.

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BACKGROUND

For more than a decade, health care experts across the globe have been warning about the looming health human resource crisis. The Covid-19 pandemic hit a health system already facing multiple challenges: an overworked workforce struggling to keep pace with service expansions in healthcare, magnified by an ageing staff and growing percentage of less experienced clinicians. The shift in workforce composition and demographics has widened an already increasing experience-complexity gap.[1] Nelson et al. found that the current Canadian system is characterized by insufficiencies in the appropriate and sustainable use of healthcare providers and resources. This is not just a Canadian problem: as Nelson et al. have argued, "The misalignment of Health Human Resources capacities with the need to provide health care services relevant to population demands is a global issue...."[2] In the report *Defining Health and Health Care Sustainability*, it was stated that the World Health Organization believes somewhere between 20% and 40% of resources spent on health are wasted due to inefficiencies including inappropriate or costly staff mixes.[3] Having all clinicians work at top of scope or licence just because the regulation allows them to do so without determining the context of the care and the care model in which they function or without addressing a care gap is also problematic. Determining the ideal scopes of practice and roles required to meet the gap(s) for particular care contexts is optimal. The Rapid Task Analysis (RTA) and the Practice Change Guide (PCG) were two fundamental tools embedded in the development and the refinement of this novel and practical Care Process Framework (CPF). A consistent approach or methodology was needed to capture the tasks (care activities) and the concepts (the education and training required to perform the care activities), involved in addressing the care needs of patients as they journey through a service or program. At the time of this study, a modified Cognitive Task Analysis (CTA) known as a Rapid Task Analysis (RTA), coined by Goffredson and Mosher in their book *Innovative Performance Support*, was an approach being used within the health authority to build education and learning and performance support resources.[4] This aligns with the Militello and Hoffman depiction that CTA methods not only help focus on better understanding of the cognitive demands of a task but also on the knowledge and strategies underlying performance.[5] The RTA was chosen and incorporated into the CPF.

Study Goals

The goal of this study was to test the 'care process' framework using the RTA consecutively in five communities to determine if the framework could be replicated and strengthened each time. The RTA, when aligned with a care process, captures the care activities of a typical patient/client journey through a service area. The care process and care activities that fall under it are captured across multiple service area programs to ideally meet the patients where they are at and 'wrap' care as seamlessly as possible. For the patients, this means easier access to services to address their primary care needs vs having to find multiple doors to access care (see **Figure 1:** Integrated Primary and Community Care - Current vs. Future State).

METHODS

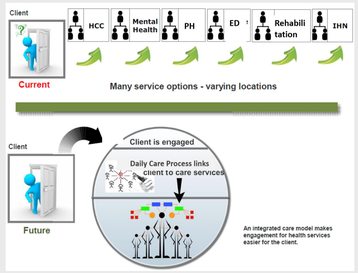


Figure 1. Integrated Primary and Community Care - Current vs. Future State

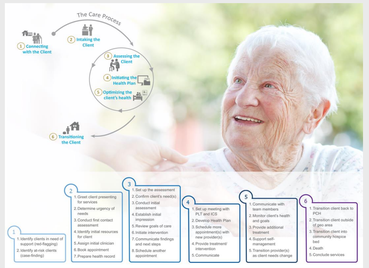


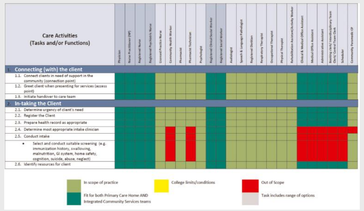
Figure 3. Macro Care Process for Integrated Primary and Community Care

The care process framework was tested across five communities as part of a province-wide British Columbia Ministry of Health priority to integrate community-based health services. Communities that expressed interest agreed to participate.
An initial review of the local health area profiles was analyzed to inform a broader understanding of the population's demographics and social determinants of health including an analysis of the hospital emergency department (ED) in each community showing what individuals' presenting complaints were. A recent review showed it is well established that up to half of the ED presentations are manageable outside of the ED.[7] Structured and semi-structured interviews, observational methods and think-aloud exercises with Subject Matter Expert (SME) leaders and staff, and refinement of this engagement approach occurred after each community tested.

Figure 2. Practice Change Guide

Using evidence and experience, a guide for leaders to work through when undergoing small to large–scale practice or care model changes was developed (see **Figure 2:** Practice Change Guide). A care process graphic was then created from this engagement with the leaders and SMEs and buckets of like-care activities are grouped together. The 'macro care process' represents the care activities or tasks an average or typical patient/client would require while journeying through a service area. For example, patients usually have different care needs depending on where they are at in their health journey mapped across the care process (see **Figure 3:** Macro Care Process for Integrated Primary and Community Care) and could have potentially different members or a healthcare team addressing care. Facilitating dialogue with the SMEs using the RTA then captured the care activities or tasks and steps under each macro care process. Next, each care activity was assigned a risk rating determined by task complexity and risk of failure to perform safely. Tacit decision-making, knowledge, or concepts needed to perform those tasks included relevant legislation, regulation, evidence-based practice standards, training, and decision-support tools. The next steps were to map different professions and roles against those tasks (audience analysis) to determine who could perform those care activities according to their regulatory scopes of practice and/or role or job descriptions, in the case of unregulated care providers (**See Table 1:** Sample of the Rapid Task Analysis (RTA) and Audience Analysis).

Table 1. Sample of the Rapid Task Analysis (RTA) and Audience Analysis



RESULTS

Our experience was that the Care Process Framework was replicable as the next team built upon the commonly observed patterns and themes and the learnings were incorporated to strengthen and validate the CPF. Even though each community had differing population care needs, the patient's overall journey consistently aligned with the same integrated and community care macro care process across the five communities. Additionally, given their knowledge of the patient population, capturing SME clinical decision-making and service delivery expertise, the CPF captured their insights to inform team functioning, optimizing scopes of practice, and determining ideal team composition to address the care, service, and/or practice gaps. SME involvement was critical in identifying the care activities experienced by the patients and informing the possibilities for future care model re-design and better aligning the care to the population care needs. For example, this analysis informed opportunities for members of the team to take on or let go of certain activities and for others on the team to perform care activities at the top of their professional scope or sometimes known as top of licence. Mapping the care activities from the patient perspective and seeing how the patient's care needs changed depending on where they were at in their health journey, leadership began to shift the assumptions they held about which professions or care team members could address the care needs and when in the care process. This shift in thinking could change how operational leaders and government agencies in the future approach care model development.

Key Take Home Messages

Our experiences consistently revealed four key lessons for scholars and leaders in this area:

- ✓ The need for strong executive leadership and sponsorship to drive engagement with the care teams.
- ✓ The conversations and recommendations related to redesigning the team and/or performance expectations challenged the existing culture of independent practice; optimizing existing staff to top of scope of practice or licence requires change leadership resources as does adding a new role, building team competency, or implementing a change in team processes.
- ✓ Building a care process and mapping the care activities using the RTA illuminated a valuable and deeper understanding of the care being provided, and only after the framework unfolded, were leaders/teams able to envision and inform a future model of care.
- ✓ For operational leaders and government agencies, using the care process framework could represent a departure from engrained historical thinking about "add more" vs. "add right" health human resources, education, and training allocation strategies.

Next Steps: Further application of our framework in other service areas is resulting in comparable results.

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