Multiskilling: Who, How, When, and Why?

The cost of health care in the United States is a national problem of major proportion, and policy makers, payers, and consumers are seeking any and all measures that will bring relief. Although many factors drive health care costs, the cost of labor (i.e., therapists) is a major contributor. As expected, the issues of therapist training and use has begun to receive attention as a possible area in which costs can be controlled and ultimately reduced. Specifically, the feasibility of replacing specialists with generalists (i.e., multiskilled therapists) is under consideration.

The Pew Health Professions Commission’s report (1993) lays out an argument in favor of the generalist. Dr. Edward H. O’Neil, a spokesperson for the commission, stated:

"Regularions need to be amended to encourage as much experimentation in changing the allied workforce as possible…unless we give the care delivery system broader flexibility…we won’t get the changes we need to bring about efficiency and effectiveness [i.e., cost reduction]…what we have concluded is that institutional identity should be balanced with professional identity." (personal communication, September 1995)

To achieve delivery system “integration,” the Pew Commission recommended that a core curriculum be required of all allied health disciplines (Foto, 1995). A student who matriculates into such a program would not receive a degree in a specialty such as occupational therapy but rather would possess a degree in allied health. This concept shows a failure to grasp the complexities of the habilitation and rehabilitation needs of U.S. citizens who have had an accident, injury, or illness. Further, it suggests that the commission does not understand that the various specialist professions evolved out of need. In reality, today’s specialists evolved from generalists who could not possess all of the knowledge, skills, and judgment required to competently meet the ever-increasing needs of the patient.

Although we may not agree with the Pew Commission’s recommendation, we share responsibility as a partner with the payers, policy makers, employers, and patients, a partner who has an equal stake in the evolution of effective cost and quality management tools. Consequently, we must not dismiss the concept of multiskilling. We must examine and discuss this concept at the state and national association levels.

To frame this issue of multiskilled providers for discussion among our membership, it may be useful to pose an obvious yet fundamental question: What does multiskilled mean? We are an association of great and wonderful diversity. Therefore, it is probable that there is also diversity in the definition of a multiskilled practitioner. Perhaps the first goal of our discussion should be to develop a consensus among the membership as to what multiskilled means and who a multiskilled practitioner is from the American Occupational Therapy Association’s (AOTA’s) perspective. This would lay the foundation to pursue the next goal of developing our action plan.

What Does Multiskilled Mean?

Does multiskilled mean one person who is trained to deliver a number of services that were previously provided by several different specialized people? This definition reflects how the concept of multiskilling is applied in many non-health care industries where the idea originated. The employment of multiskilled personnel has allowed these industries to cut their costs through workforce reductions. We are now beginning to see this concept enter the health care industry. For example, in some hospitals, nurse’s aides not only carry out such traditional nursing jobs as taking vital signs, bathing patients, and assisting them...
with meals but have also been trained to perform electrocardiograms, draw blood, assist with exercise programs, and set up traction. Can this concept be applied to rehabilitation specialists? To pursue this possibility, we are required, as well as other disciplines, to take two difficult steps. First, we would have to recognize that not all that we do in delivering services requires the knowledge, skills, and judgment of an occupational therapist. Second, we would then need to identify which of our services are skilled and which are nonskilled, as well as identify when the delivery of a skilled service could be provided by an aide under supervision. A greater commonality may exist among the therapy disciplines in the nonskilled services they deliver than in the skilled services. If so, we need to identify a curriculum that would educate and train a rehabilitation aide, a provider who would be valuable to all therapy disciplines. With this move, costs would be reduced and controlled in two ways. First, nonskilled services would be reimbursed at a lower level than skilled services, and second, a rehabilitation aide’s salary would be less than that of an occupational therapist. If costs are reduced and controlled, it is more probable that frequency and intensity of services will not be diminished by payers, thereby preserving quality of care.

Does Multiskilled Mean a Cross-Trained Therapist?

Should therapists gain a greater awareness, understanding, and knowledge of the other disciplines with whom they work? It is conceivable that costs would be reduced and quality of care enhanced if organized cross training was provided. Although the knowledge and skills of each discipline would be provided in the traditional manner, every therapist, at some level, would be able to reinforce or treat with each other’s goals in mind. This scenario is already beginning to happen in many settings. For example, in one stroke rehabilitation program, all team members are trained in transfers, positioning, passive and active range of motion, dysphagia feeding techniques, stress management, and methods to facilitate and reinforce communication. As indicated on a case-by-case basis, the team determines how each member can incorporate these areas into his or her treatment plan. Additionally, each team member is responsible for responding to patient needs in these areas as they arise. For example, if a patient who uses a wheelchair needs to go to the bathroom during a speech therapy session, the speech-language pathologist does not make the patient wait, stop the treatment session, or call a nurse. Instead, he or she takes the patient to the bathroom and facilitates the transfer. If and when appropriate, the speech-language pathologist also uses this activity as an opportunity to continue treatment in the context of a functional activity. It is probable that cross training would reduce length of stay (i.e., cost) and enhance quality by increasing the continuity of care.

Does Multiskilled Mean a Universal Core Curriculum?

Is there a body of knowledge that is universal to and required by two or more therapy disciplines? For example, is the required knowledge of anatomy, physiology, neurology, psychology, learning theory, and general therapy principles universal across therapy disciplines? If it is, a core curriculum could be constructed. In this scenario, the therapists would first acquire a common body of knowledge and then specialize in a specific therapy discipline. This approach would not result in a multiskilled practitioner, but a common general knowledge base could indirectly result in cost control and quality enhancement. It may result in greater consistency and uniformity in the clinical decision-making process that each discipline uses to determine whether treatment should be provided and when it should be discontinued.

Is the multiskilled deliverer of service one of these possibilities, a combination of these possibilities, all of these possibilities, or none of these possibilities? There are many other ways of looking at this question. My intention here is to raise questions that will hopefully stimulate discussion and debate. There is neither an easy nor a single answer to this question. However, we must strive to identify our areas of consensus and from consensus build an action plan. As I stated in my presidential address (FOTO, 1995), we are “facing a major fork in the road of our professional development” and now is the “time to choose which road we will take.” (p. 958)

Of the numerous choices I mentioned, three are particularly germane to the issue of a multiskilled practitioner (FOTO, 1995):

- We can choose to seek cooperative, positive means of responding to the changing state of health care or continue on our existing path, which may feel more familiar, comfortable, and safe but no longer fits the realities that surround us.
- We can choose to seek and foster cooperative arrangements with other professions or seek hierarchical supremacy via interprofessional competition—a road in which the consumer is the ball and we are at match point.
- We can choose to embrace the new health care system and work for change within it, or we can continue to deliver services in the same old ways, ignoring how the new system is affecting our future. (p. 958)

We must respond to the challenges, opportunities, and choices presented to us by the dynamics of our rapidly and constantly changing health care system. We must take a responsible and reasoned partnership role in the quest to reduce and control health care costs. However, we must objectively and unemotionally evaluate the validity of each and every proposal. We have been told that managed care will reduce and control costs, and there is growing concern that this is not happening. To the contrary, evidence is emerging that the costs have simply shifted from payments to health care providers to health care investors’
profits. Now, we are being told that we are a major source of the problem. There is a call for salary equivalency and a multiskilled therapist. These proposals must be carefully studied to determine whether their implementation will, in fact, contribute to cost reduction and control. Finally, all of us are experiencing the very real impact of previous changes on our patients. Service availability and quality are eroding. While we push forward with change, we must simultaneously advocate on behalf of our patients. Our focus and the basis of our decisions must always be directed toward the preservation of the quality of patient care, not the protection of our profession.

References