afhto association of family health teams of ontario

CASE STUDIES

OPTIMIZING INTERPROFESSIONAL RESOURCES & SPREADING ACCESS TO TEAMS

Summary

East GTA Family Health Team and the Guelph Family Health Team have successfully implemented service delivery models that provide community residents and patients of non-FHT physicians with access to interprofessional programs. Key to their success has been board commitment to a vision of team based primary health care that is readily available to the entire community, supported by strong leadership (Board and Executive Director) and committed staff teams.

Introduction

Under the ***Patients First***[1] action plan, the Ministry of Health and Long-Term care is introducing reforms to support a population-based approach to health care planning and delivery. Through the creation of sub LHINs, the aim is to identify and align patient health service needs within a defined region, and to provide easier access, better coordination and improved continuity of care.

A key focus of the *Patients First Act* is the further integration of primary care, along with more timely, equitable access. Evidence tells us that with a team-based approach to primary care, patients experience more timely access and better care coordination, yet only 25-30% of Ontarians currently have access to team-based primary care. Is there a way to spread access to teams more broadly in communities? Can we optimize the use of team resources to maximize access without causing undue stress on providers, unacceptable increases in wait times, and/or decreases in quality of care? How can we measure/define team capacity and balance additional demand within current resource constraints? And how do we address equity of resourcing across primary care teams to support the ability to spread access? These questions all need to be carefully considered if we are to create equitable access to team-based primary care for those who would most benefit.

In order to spread access to team-based care, FHTs/NPLCs must also consider optimal use of staff skills and resources.

The following two case studies document the experience of two Family Health Teams that have expanded access in their communities by providing programs and services to people who are not rostered to the FHT physicians. The experience of these two teams may help inform other FHTs/NPLCs as they begin to contemplate their own ability to expand access and optimize the value of their team.

Following the case studies, the discussion will focus on advice and lessons learned.

Guelph Family Health Team

Background

Guelph Family Health Team is a well-established team that was funded in 2007. It serves a medium-sized city where the majority of family physicians are affiliated with the FHT. The FHT has a physician-led board, operates from over 20 sites and employs about 70 FTE interprofessional health care providers. The FHT has a roster size of about 100,000 patients and offers some of its programs and services to 10,000 additional people who are patients of non-FHT physicians.

The Motivation

The idea to expand service beyond the FHT's rostered patients arose from a Board and staff commitment to embrace the ***Patients First*** agenda and look for ways to eliminate barriers to access at a community level. There is a strong commitment to improve overall health system effectiveness and efficiency and increase accessibility to primary care for the entire community.

The FHT's diabetes program had always been open to the whole community and provided good experience to build on. Under the banner of *Health Links*, the FHT slowly began to open up other FHT services beginning with home visit nurses and social workers in the *Primary Care at Home* program. Other group programs are now also being made available in the community. The next objective is to embed some services in non-FHT affiliated physician offices.

The Process

The Board played an important role in establishing the strategic direction to decrease barriers to access, and creating a patient-centred culture across the organization.

Guelph FHT is a well-established and successful FHT. The affiliated physician groups were faithful users of FHT programs and services. This meant that the FHT needed

[1]Ministry of Health and Long-Term Care, *Patients First: Action Plan For Health Care*. Queens Printer for Ontario, 2015. Web. 19 Apr. 2016.

to develop a strategy to balance supply and demand and free up resources to serve the broader community. The FHT assessed which IHPs were being less well used and was able to carve off two FTEs to make available to non-affiliated physician practices in the community. The FHT also reduced one management position and converted it to patient care. Even still, the FHT is spreading itself quite thin to meet its strategic direction.

The executive director played a strong leadership role in the planning and implementation. He contacted the family physicians who were not affiliated with the FHT, promoted the programs the FHT could make available to their patients, worked with the team to develop processes for receiving outside patients and reporting on progress, and developed the communication strategy for informing the community.

The process of identifying community need and FHT capacity to respond is ongoing.

Enablers

The following enablers were instrumental in ensuring the success of the initiative:

- **Leadership:** Guelph FHT is fortunate to have strong leadership from the Board and the Executive Director. It is an organization that lives up to its values and makes decisions based on those values.
- **Organizational culture:** Guelph FHT and the affiliated FHOs have a strong organizational culture that supports improved access and places the patient at the centre of care.
- **Engagement and communication:** The Board, ED, IHPs and FHO physicians were all engaged with the process and maintain good communication with the stakeholders. Engaging the community was relatively easy because the community physician practices were readily identifiable due to the small number of physicians who are not part of the FHT.
- **Organizational processes:** The FHT has well developed policies and procedures for EMR security and support, privacy, measurement and quality improvement that were leveraged as part of this expansion.

East GTA Family Health Team

Background

East GTA FHT was founded in 2011 and is located in Scarborough. At its inception, it had a physician-led Board, employed 13 IHPs and was affiliated with 17 physicians organized within 2 FHOs. The FHT is unusual in that fully two-thirds of the people it now serves (approximately 40,000 of 60,000) are patients of family practices that are not affiliated with the FHT. From the outset, the FHT struggled with governance issues, reflected in the resignation of 12 of the original 17 MDs, and resultant insufficient uptake of FHT programs and services. Early governance and leadership resulted in a largely dysfunctional team.

When East GTA FHT began offering its programs and services for outside use, the FHT was quite new and its programs were not used to full capacity. Initial programs included Diabetes, Healthy Living and a few others; later these were supplemented with other population-based programs e.g. Cardiovascular, Mental Health, Lung Health, Maternal Health and Seniors Health. Programs are accessible to outside physicians/other providers or patients may self-refer. For prospective community patients for the mental health program, some restrictions were put in place for home visits to safeguard the safety of providers since the patient history is not fully known to the FHT initially.

The Motivation

The clear motivation behind the move to offer services to non-FHT physicians was survival. The Ministry of Health and Long-Term Care had expressed its concern about FHT governance and FHO membership (which kept changing). The funder asked for a response within a reasonable period of time. When this did not materialize, the Ministry withdrew its funding. This was indeed a turning point for the FHT.

The Process

The Executive Director crafted a clear set of strategies designed to make the community aware of the FHT's programs and services. In 2012, an Outreach Committee consisting of a few IHPs was formed to canvass the community. Family physicians and a wide range of community services organizations were

advised that FHT programs and services would be offered to patients in the community without any charge on a first-come, first-served basis.

In 2013, concurrent with the above outreach strategy, the Executive Director also undertook an 11-point modernization plan to transform the Board to a skills-based, fully engaged Board that shared responsibilities. A number of significant improvements were made to the governance model and practice, allowing the Board to focus on its fiduciary and strategic responsibilities.

The Executive Director played a strong leadership role in the expansion of programs to non-FHT patients, beginning with the modernization of governance, and the development and execution of a well thought out and Board approved set of strategies for improving access including oversight of capacity utilization, measurement of program outcomes, and review of access results. The importance of keeping the patient's Family Physician informed was recognized at the outset, as was input from patients. It was imperative to keep the Ministry apprised of the progress and challenges throughout the journey. Aside from the governance challenges, there were no significant obstacles to creating the foundation for improved access to the FHT interprofessional team. Intake and reporting processes were established to ensure that patient records and patient status are current.

Enablers

The following enablers were instrumental in ensuring the success of the initiative:

- **Leadership:** East GTA FHT relied heavily on the leadership and experience of the Executive Director, excellent support from the Board and IHPs who were empowered to do the right things in the right way consistent with the Vision and Values established for the FHT. While this transformational change was taking place, a system was used to monitor capacity utilization and trends on a real time basis to ensure that IHPs were not stretched to the point of burn out.
- **Relationship building:** It was important for the FHT to build and maintain a strong relationship with the Ministry of Health and Long-Term Care, local elected officials at Queen's Park and City Hall as well as with non-FHT physicians, hospitals and community organizations in Scarborough and surrounding areas. Building new and strong relationships with stakeholders in the community ensured uptake of the FHT's programs, sharing of resources and support for patients to navigate the system.
- **Focused implementation:** The Executive Director in partnership with the newly elected Lead Physician implemented the FHT's programs with intense focus. Non-FHT physicians and their patients were identified, provided with information and easy access to well run programs. An IHP was identified as "champion" to lead each of the programs with support from the Lead Physician and the Executive Director. This was essential to building and expanding the model.
- **Communication and team building:** Communication both externally and internally was essential to ensure team buy-in and continuous improvement in the delivery of programs and services.
- **Developmental stage:** Because East GTA FHT was in the early stage of development and there were significant governance and physician issues at the outset, there was capacity to extend the FHT programs to the broader community.

Discussion

Evidence shows that patients experience more timely access to care, better care coordination and improved management of their chronic disease with a team-based approach to primary care. How then do we maximize access to primary care teams and get the best value for this investment? AFHTO has looked at the research and presents a set of principles and an initial set of recommendations in its position paper "Optimizing value of and access to team-based primary care".

Despite starting from different motivators, both of these FHTs began with leadership commitment to a strategic direction and change. Both FHTs were very successful at deploying their resources to provide care to the broader community. Both FHTs embraced the challenge and opportunity to innovate and to chart a new direction for the provision of collaborative, team-based care to a broader population base.

OPTIMIZING INTERPROFESSIONAL RESOURCES & SPREADING ACCESS TO TEAMS

A shift in the provision of team resources to the broader community will be a significant change to the status quo. The advice and lessons learned from our two case studies align well with the literature review conducted by AFHTO and may help to guide other FHTs/NPLCs as they consider the ability of their own organizations to expand access.

Advice and Lessons Learned

1. **Optimizing capacity and resources**

   In considering an expansion of existing services to new populations, a logical question relates to whether and how finite resources can be applied to meet expanding need. Small FHTs/NPLCs may find it more difficult to extend their resources beyond their rostered patients. Inequities in team resources available in different communities also creates differences in capacity and abilities to spread access.

   Both Guelph and East GTA FHTs are taking a similar approach to ensuring that the organizations' skills and resources are put to optimal use. Strategies for ensuring optimal allocation of resources include:

   - Continual review of business and clinical processes to assess how things might be done better and more efficiently.
   - A detailed appraisal of the use of FHT clinicians so that resources can be better allocated. This review includes such things as assessment of demand for services, detailed costing of IHP visits and educating staff on the cost of their time, assessing staff utilization to identify ways to improve allocation of FTEs and confirming that staff are working to their full scope of practice. In East GTA, the referral patterns of each physician (FHT and community physicians) are reviewed, and linked back to the patient survey from each practice.
   - Developing robust data that allows FHT services to be targeted to the highest need – e.g. frail, elderly patients with complex conditions.
   - A strategic approach to professional development beginning with a skills inventory. Who is best at what? Is there redundancy? Where do we train and how do we best allocate our resources?
   - Good understanding of community needs and a matching of need with available resources. In East GTA FHT for example, a physiotherapist position was created replacing an NP position to better serve the needs of the seniors' population without any financial means or insurance. This has been a huge success with the frail, elderly population, who are staying at home longer with in-home support from both the PT and the OT.

   As the province shifts to population-based health care planning and delivery, establishing sub-LHIN regions and ensuring that all Ontarians have access to a primary care provider and that team-based interprofessional care is accessible for those who need it most, key stakeholders are in a position now to consider their roles and how best the primary care sector can position itself to support expanded access and better integration of care.

   The expansion of access to inter-professional teams represents a significant change in the culture of FHT/NPLC operations. Leadership must be willing to embrace change and must be engaged in managing a change in organizational culture and approach.

   For example, physicians and NPs need to be thinking about who needs to see a FHT clinician, rather than who could see a clinician. This perspective will help to identify a model for optimal allocation of staff time and other resources.

   Where physicians, NPs and other clinicians have contributed substantially to the building of the team, there may be some resistance to overcome when considering providing other physicians with access to FHT/NPLC resources. Strong leadership and vision are required to support physicians through change and transformation.

2. **Governance and Leadership**

   Governance is at the centre of everything. If you get the governance right, everything else will flow more easily. Leadership training, mentoring, and knowledge exchange can help to support Executive Directors and Boards as they navigate this change.

Strong governance is essential. It is important to have the commitment of your Board, as well as the support of physicians and IHPs. A forward thinking Board that is committed to a meaningful discussion of the FHT/NPLC's role in ongoing system transformation and that is vigilant about managing risk, is essential to guide innovation.

A skills-based Board, with representation and skills from the community, may be helpful in charting a new direction for FHTs/NPLCs. Skills ranging from negotiation and change management to conflict resolution, public relations, risk management and strong financial and human capital management can be valuable resources to effect change. Alternatively, with a provider-led Board as in Guelph FHT, visionary physician leadership is critical.

Regardless of the FHT/NPLC's governance model, Boards must be willing to consider their role and their responsibility to contribute to health sector discussions of system transformation. Boards must be prepared to challenge themselves and to define their purpose; does the Board's role extend beyond responsibility to the specific stakeholders of the FHT/NPLC (physicians, IHPs, staff, rostered patients) or to the larger public good?

3. **Communication**
Communication becomes increasingly complex, with more stakeholders, more relationships, more messages and more channels. Ensuring good communication will help build relationships, ensure the sharing of new ideas and best practices, and improve health outcomes.

4. **Team work**
Effective teamwork is essential with more partners, more relationships and significant change. Care must be taken to monitor the teams – for effectiveness, and also for burnout, as demands increase and there are a growing number of relationships with new physicians and patients.

5. **Needs Assessment**
It is important to understand the needs of the community, and to align the FHT/NPLC's programs with needs and priorities identified by the LHIN.

6. **Knowledge Exchange**
Change in the primary health care sector is underway and will continue. Knowledge and information will be critical to ensuring the success of innovation and changes in care delivery across the province. A key role for AFHTO could include continued focus on knowledge exchange and training, in such areas as:

- Leadership development
- Sector trends, themes and direction
- Dissemination of information and strategies