afhto association of family health teams of ontario

AFHTO's summary of the Conference Board of Canada's Final Report -- *An External Evaluation of the Family Health Team (FHT) Initiative*

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Report summary and supporting facts

1 AFHTO welcomes the FHT evaluation report. It provides important insight to guide the work by AFHTO and its members to improve and deliver optimal comprehensive primary care.

- AFHTO's mission is to provide leadership to promote expansion of high-quality, comprehensive and well-integrated interprofessional primary care for the benefit of all Ontarians, and to support our members to improve and deliver optimal comprehensive interprofessional primary care.
- Evidence drives improvement. AFHTO has been looking forward to the results of this evaluation study to guide our work with all interprofessional teams in our membership. FHTs that participated in this study are looking forward to receiving their individual results to focus their on-going improvement activity.

2 The FHT evaluation report shows clear evidence of improvement over the study period, 2009-2012.

2.1 Patient survey data suggests the ability to get same-day appointments in FHTs ranks among the best in the world for primary care.

- Many FHTs have implemented same-day / advanced access and many patients reported improved wait times
- 79% of patients reported they could definitely (36%) or probably (43%) get an appointment on the same day. (p.47)
    - This compares to an international survey that found 40% of Ontario residents said they were able to see their primary care provider on the same day or next day when they were sick.
    - Internationally, this survey found the best performance was 72% of patients in Germany reporting same day or next day access to their primary care provider.
        - Data source: 2013 Commonwealth Fund International Health Policy Survey, as reported in *Measuring Up*, Health Quality Ontario, 2014 (p. 36).
- Several patient focus group participants indicated that timely access to providers is one of the things they valued most from their FHTs. (p.47)
- In the FHTs where wait times for physicians decreased, many providers interviewed believed that addition of IHPs had been critical. (p.45)
- At the same time, waits of up to four weeks and longer were reported for some types of services, particularly for mental health. (p.45)

2.2 FHTs are getting better organized and improved structures and processes within the organization are associated with improved patient experience.

- "Better organized" means better governance, better communication and team work, better EMR use, better community relationships, better QI, and better chronic disease management.
- Average scores for all of the FHT management and governance scores increased from 2009 to 2012, especially in activities related to planning and programming (p.106).
- Within this, the most significant improvements were in activities related to planning and programming, shorter wait times, use of completely paperless records (EMRs) for internal services; and information continuity (pp. 102 to 103).
- Important, but smaller, improvements included increased: staff training and mentorship, use of EMR functionality, use of paperless records (EMRs) for external services, linkages with external providers, use of data and quality improvement activities. (p.101 to 103)

2.3 FHTs are offering a wider range of programs and services to promote health and manage chronic disease.

- FHT staff reported that formalization of chronic disease management services had been one of the most significant developments in their FHT (p.67)
- Patients also expressed an appreciation of the range of services available and the “one-stop shopping” available at many FHTs– with access to a variety of services within one group of providers and without cost. (p.54) Those participating in chronic disease management programs are more confident about self-management
- Interprofessional health providers (IHPs) have played an important role in conceptualizing, designing and implementing such programs. IHPs brought extensive knowledge of and linkages to external services and were able to provide one-on-one internal services for those with chronic conditions. (pp.v, 67, 69)
- Around half of patients received reminders for follow ups, spoke about their disease goals and worked with a provider to plan their daily treatment. (p.v, 70)
- Tangible results of such interventions include improved blood pressure control among those with hypertension, cardiovascular disease, or stroke and improved A1c blood sugar control among diabetics. (p.v, 71, 72)
- Size of FHTs is a factor regarding types of programs and services offered. Generally, larger FHTs, with more resources and administrative staff, had more programs. Several smaller FHTs offered one-on-one collaborative care rather than targeted programs and leveraged community resources to augment their services. (pp.52 + 67)

3 The FHT evaluation report gives some evidence of the added value of interprofessional primary care. Unfortunately the report is highly limited by the lack of data from clinical records, total cost of care and health outcomes.

- The evaluation report is based on surveys of patient experience, FHT-reported organizational structures and processes, and providers' assessment of organizational policies, structures and processes, There is virtually no assessment of clinical processes nor health outcomes.
- Primary care is both a "customer service", i.e. patients should have a good experience of care, and a "clinical service", i.e. patients expect professionals to use appropriate clinical judgment to help them maintain optimal health. While the report provides very useful insights, the lack of clinical data is a serious limitation of this evaluation report.

3.1 The only clinical data available in the report shows that FHTs performed significantly better than fee-for-service physician models (FFS and EFFS) in cancer screening and the same or better in diabetes care.

- The ICES analysis compared FHT performance on a few key indicators to CHCs, FFS (fee for service), EFFS (extended FFS or "comprehensive care model"), FHNs (family health networks) and FHOs (family health organizations) in 2012. (p.100)
  - Note: CHCs are interprofessional organizations. All the others are physician models.
- Demographic and case-mix differences among patients in the different models were adjusted for age, sex, income quintile, morbidity, comorbidity and rurality. (pp.99 and 100)

3.2 For the three models for which patient experience surveys were conducted – i.e. FHTs, community health centres (CHCs) and family health groups (FHGs) – the results show no statistically meaningful differences in patient experience scores over time, nor compared across models.

- CHCs also deliver interprofessional primary care, and have done so for about 30 years (compared to under 10 for FHTs). They are focused on high needs populations. FHGs are physician groups.
- **Overall patient-reported experience scores** in both 2009 and 2012 were at the upper end of the range in all three models (i.e. 72 to 77). Statistically, there was no meaningful difference between the models in 2012 and no meaningful change for any of the models between 2009 and 2012. (p.83, 97)
  - Results for FHGs who participated in this study MAY be higher than that for all FHGs in Ontario. The chair of the FHT Evaluation Advisory Committee noted there was difficulty in recruiting FHGs to participate; making it likely that those who finally did participate would be higher performers than those who refused.
- **Within each of the six domains of patient experience at follow up**:
  - In 2012, three domains scored between 79 and 83: access, internal coordination and specialist care coordination. (p.84)

- Three domains scored in the 60s: prevention and health promotion, patient support for chronic disease management and patient and family centredness (latter was low 70s for CHCs). (p.84)
- Only one of the six domains showed any statistically meaningful difference – i.e. CHCs scored somewhat higher than FHTs and FHGs on patient and family centredness (i.e. 71.8, 64.9 and 63.5 respectively) and higher scores than FHGs in terms of chronic disease management. (p.94 97)

4 There is variation in performance among primary care providers. The FHT evaluation report provides further evidence and direction for the Ministry, AFHTO, FHTs and other primary care organizations together with their associations, on what is needed to continue to improve.

- The FHT evaluation report has identified organizational and structural characteristics that are associated with improved patient experience. This gives some foundation for FHTs and other primary care organizations to assess themselves on the basis of these characteristics and consider how to improve in these areas.
- Almost half of FHTs were the best performers in some domains and lowest in others
- High and low-performing FHTs were differentiated by their culture, leadership and management practices, use of data and patient information, and patient experience with staff (e.g., reception and continuity of care)

4.1 We have better understanding of factors that have improved patient experience in accessing care.

- For access to same-day appointments, factors that have contributed to its improvement include having a systematic approach, strong leaders, supportive staff, time dedicated to support the change and a patient scheduling model adapted to reflect practice and patient needs.
- In FHTs where wait times for physicians had decreased, many providers interviewed believed that the addition of IHPs had been critical. (p.45)
- The greatest difference between the best and lowest performers in terms of access were in the extent of provider involvement in quality improvement activities and paperless medical records within the FHT. (p.169 180)
- The concept of “access” is not limited to in-person appointments:
  - Patients highly valued access to their providers via telephone and e-mail.
  - Patients appreciated reminders for screening and other tests, but wanted better access to their own health information. (p.42)
  - Having access to their health records and laboratory results was associated with better patient experience in a number of areas (p. 120, 180, 183)

4.2 Governance and leadership is critically important to performance.

- Top-rated FHTs were more likely to have:
  - Greater understanding among providers of the FHT's mission, vision, goals, and priorities;
  - Patients access to their own medical records
  - providers with higher team functioning, more types and frequency of interaction and greater adherence to clinical guidelines;
  - a strong team culture as reflected in FHT policies, activities and interprofessional teamwork;
  - providers who interacted with their patients by telephone and/or e-mail;
  - greater patient and family centredness;
  - greater patient satisfaction with receptionist services. (p.169, 180)
- Almost all of these factors are related to priorities established, decisions made and behaviour modelled by the governors and leaders of organizations.
- The FHT evaluation report also points to some areas where there is room for further improvement— potentially in some FHTs more than others. Governors and leaders will want to consider the areas identified in the report, i.e. better use of patient data, increased external linkages and interoperability of FHT and external medical records, better articulation of governance and health human resources policies, increased regular team meetings, increased family centredness, greater provider teamwork and more provider involvement in quality improvement activities. (p.102)

4.3 Better use of patient data, linkages and interoperability and quality improvement are also key.

- As noted in #4.1 above, the greatest differences between the best and lowest performers in terms of access were in the extent of provider involvement in quality improvement activities and paperless medical records within the FHT. (p.169)
- Planning based on patient profiles, information continuity, and patient access to the own data were also found to be important (120)
- In the list of areas for improvement in #4.2 above, there is room for improvement in better use of patient data, increased external linkages and interoperability of FHT and external medical records, and more provider involvement in quality improvement.
- With government funding since August 2013 for the Quality Improvement Decision Support (QIDS) program, noted in #5 below, improvement in these areas is being directly supported.

4.4 The most notable findings indicate that staff make the biggest difference to patient experience; however recruitment and retention of staff is particularly challenging. The FHT evaluation report's findings reinforce those of previous AFHTO reports – below-market compensation is a problem; adequate funding is needed to solve it.

- The Executive Summary of the FHT evaluation report states:
  - "The best-performing FHTs in 2012 were set apart by certain characteristics. Most notably, a very satisfying encounter with a receptionist produced patient

experience scores that were 18 points higher than a very dissatisfying encounter, and improving the quality of reception was associated with increased scores between baseline and follow up. Further, each additional meeting with an IHP was associated with an increased patient experience score of two points." (p.vi)

- The extent to which patients reported in the patient survey that they usually saw the same physician or nurse was associated with better patient experience ratings in most domains. (p.120 139).
- Availability of and continuity with skilled staff is absolutely critical to high quality patient experience, and yet some FHTs experienced significant challenges related to recruitment and retention, which impeded the team's overall performance. Smaller FHTs felt the departure of staff most acutely, and in some instances needed to suspend a program if an IHP left. "Hiring for fit" was reported to be critical for team functioning (p.153)
    - The report's findings provide further evidence of the recruitment and retention challenges documented in two reports by AFHTO (jointly with the Association of Ontario Health Centres and the Nurse Practitioners' Association of Ontario), due to insufficient funding to provide competitive compensation. (Reports can be accessed at http://www.afhto.ca/wp-content/uploads/Toward-a-Primary-Care-Recruitment-and-Retention-Strategy-January-2014.pdf and http://www.afhto.ca/wp-content/uploads/AFHTO-AOHC-NPAO-Recruitment-+-Retention-Report-2012-02-06.pdf)
    - The FHT evaluation report found that "Compensation levels impacted on IHP recruitment and retention, with FHT some staff reporting about a 20 per cent difference between hospital and community-based salaries, and FHT salaries. Some IHPs stated that they were actively looking for other employment because of their salaries, while others said the lower compensation was mitigated by the FHT's collaborative work environment and better work-life balance. (p.153)
- When it comes to staffing FHTs, government support is sorely needed. In addition to the challenge to recruit and retain staff, the report found:
    - The IHP-to-patient ratio varies greatly among FHTs, especially related to mental health services. The overall FHT ratio of rostered-patients-to-IHP FTE ranged from approximately 120 to 3,440 patients per IHP. (p.153)
    - Some FHTs with only part-time IHP positions reported that this could impede their ability to provide adequate care. (p.153)
- Action is also being taken within FHTs to ensure wages and working conditions are harmonized for all staff.
    - The FHT evaluation report found in several FHTs, there were wage differences between physician-funded staff positions for receptionists and nurses and FHT-funded positions, resulting in differing lines of accountability, salaries, and benefits. This lack of harmonization can significantly impede a collaborative culture and performance. In addition to remuneration, some of these FHTs had different policies for staff (e.g., vacation time). (p.154)
    - Some of the FHTs that had discrepancies at baseline have harmonized wages, benefits, and hiring practices across the FHT and physician staff. These changes were observed in FHTs with both high and low patient ratings.(p.154)

5 Improvement continues, assisted through government funding since August 2013 for Quality Improvement Decision Support (QIDS) Specialists and AFHTO's provincial QIDS and Governance + Leadership programs. The AFHTO membership is advancing to achieve optimal quality, access and total cost of care, in line with public and patient expectations.

- In the study period 2009 to 2012, FHTs managed to achieve these improvements with limited support, i.e. access to learning and coaching in quality improvement through the Quality Improvement and Innovation Partnership until about 2010, and to a Health Quality Ontario learning program on advanced access techniques until 2013.
- Since its early days as an association, the AFHTO board and membership have identified the strategic priority to advance governance, leadership and use of data and measurement as the keys to improving health and health care. On behalf of members, AFHTO pressed for adequate support to build capacity in these areas.
- The province set out a "Focus on Quality in Family Health Care" in its January 2012 *Action Plan for Health Care*. This eventually led to funding, confirmed in August 2013, for AFHTO's proposal for improving governance and measurement.
    - This funding enabled 34 FHTs to hire Quality Improvement Decision Support (QIDS) Specialists to be shared in partnerships covering roughly 160 of Ontario's 185 FHTs.
    - The funding also established a provincial QIDS program through AFHTO, to provide expert support, coordinate collective activities and accelerate spread of knowledge across the QIDS Specialists and people working in AFHTO-member organizations.
    - Further to this, an AFHTO-led Governance and Leadership program to strengthen knowledge and skills, particularly in the area of quality improvement.
- Since that time FHTs have completed two initial rounds of developing annual quality improvement plans, and the first-ever set of team-based performance indicators from data that are currently available, comparable and mean the most to AFHTO members in their efforts to advance quality of care for their patients.
- AFHTO's "Starfield Principles" set out an approach to optimizing performance of primary care teams through measurement and feedback in terms of quality, capacity and total system cost.
    - The approach is based on the findings of international research in primary care conducted by Dr. Barbara Starfield.
    - The approach has been published as The Starfield model: Measuring comprehensive primary care for system benefit, in Healthcare Management Forum – Volume 27, Issue 2, Pages 60–64, Summer 2014.
- Ontario is well-positioned to continue strengthening the value of comprehensive interprofessional primary care. Continuing support from the province is needed to:
    - strengthen capacity to lead and measure quality, access and total cost;
    - enable recruitment and retention of the skilled professionals essential to provide comprehensive primary care; and
    - expand access to interprofessional primary care to all Ontarians who need it.