

# HS2045

WEEK FOUR

September 30, Oct 2, 4, 2013

# HS 2045

## Class #1: Primary Health Care

September 30, 2013

REMINDER: Poll #2 (opened 12:30 Friday, closes 12 Wednesday) > graded Wednesday

- Apply model to emerging trend

UPDATE:

No grade for participating in Poll last week

# Readings for This Week: Reminder. Expected.

- Monday

1. <http://www.hc-sc.gc.ca/hcs-sss/prim/about-apropos-eng.php>
2. [http://www.conferenceboard.ca/press/newsrelease/12-10-31/primary care teams are not as effective as they could be because of three sets of barriers.aspx](http://www.conferenceboard.ca/press/newsrelease/12-10-31/primary_care_teams_are_not_as_effective_as_they_could_be_because_of_three_sets_of_barriers.aspx)

- Wednesday

1. <http://www.longwoods.com/content/18669>

# Other Updates

# What is PRIMARY HEALTH CARE?

# PHC

- Approach to health and a spectrum of services beyond the 'traditional health care system'
- Includes:
  - SO-C-DH
  - Income
  - Housing
  - Education
  - environment

# What is PRIMARY CARE?

- PHC ≠ PC
- But PC is part of PHC
  
- Element w/in PHC that focuses on health care services
- Incl:
  - H promotion
  - Illness/injury prevention
  - Dx & Tx of illness and injury

# PHC

- Responsive to community needs
- Various governance models
- No one size fits all approach/model

# PHC as an emerging trend.

- 'status quo' is a lack of emphasis on H Promotion
- Lack of continuity of care
- Problems with access
- HCPs dislike their working conditions (long hours, impact on family life)

# PHC as an emerging trend.

- PHC reform
- Shift to teams
  - Information sharing?
  - Well positioned for H promo?
  - Teams are better for pt care?
  - Better coordination?

# You know it's an emerging trend when....

- Primary Health Care Transition Fund
- \$800M (PHCTF); Funds were allocated on a per capita basis
- Over a six-year period (2000-2006)
- Collaboration among federal, provincial, and territorial governments was a key element
- direct support to individual provinces and territories,
- also supported various pan-Canadian initiatives to address common barriers,
- offered the opportunity for participation by health care system stakeholders.

# Common Objectives of the PHCTF

1. increase the proportion of the population with access to primary health care organizations which are accountable for the planned provision of comprehensive services to a defined population;
2. increase the emphasis on health promotion, disease and injury prevention, and chronic disease management;
3. expand 24/7 access to essential services;
4. establish multi-disciplinary teams, so that the most appropriate care is provided by the most appropriate provider; and
5. facilitate coordination with other health services (such as specialists and hospitals).

# PHCTF

- The PHCTF consisted of five funding envelopes.
  - Provincial/Territorial
  - Multi-jurisdictional
  - National
  - Aboriginal
  - Official Languages Minority Communities
- evidence base remains relatively modest

# Models of PHC Teams

1. FHT: interdisc; docs + allied HCP
2. GHC: interdisc; only 1
3. FHG: docs, traditional, FFS
4. FHN: docs; capitation + blended
5. FHO: docs (plan to expand); capitation + blended
6. PCN
7. HSO
8. CCM: 1doc, FFS
9. RNPGA: 1-7 docs; serve R&N
10. CHC: teams of docs/RN/counselor/diet; serve high risk; Salary

# Teams

- Two or more people who interact and mutually influence each other to achieve common goals
  - Upper limit for meaningful composition
  - Dependent on each other to fulfill goals
  - Requires communication to coordinate tasks
  - Members mutually influence each other.

*McShane (1999) Canadian Organizational Behaviour, McGraw-Hill Ryerson*

# Team Context and Design

Overall team effectiveness depends on:

1. Organizational environments
2. Task Characteristics
3. Team Size
4. Team Composition
5. Team Cohesion

# Team Context and Design

## *1. Organizational environment:*

- The extent to which structures are in place to support teams in executing objectives and activities.
  - *E.g.: Physical layout*

## *2. Task Characteristics:*

- the extent to which the tasks are feasible to implement with given resources.
  - *Better when tasks are clear*

# Team Context and Design

## *3. Team Size:*

- the extent to which team size enables teams to collaborate and communicate to achieve outcomes
  - *Team size must fit the task*

# Team Context and Design

## *4. Team Composition:*

- The extent to which the members and characteristics of a team enable the team to achieve goals
  - *Homogenous teams: common experience; common expertise & attitudes towards working as a unit =better relations; better on simple tasks more efficient coordination*
  - *Heterogeneous teams: agreeing on group norms and goals better for creative, diverse or complex tasks*

# Team Context and Design

## *5. Team Cohesion:*

- commitment to shared power and status
- commitment to end goal

# Types of Teams

1. Multidisciplinary teams
2. Interdisciplinary teams
3. Transdisciplinary teams

# Multidisciplinary teams

- Different health professionals, distinct disciplines
- Share the same treatment space (typically work in the same building)
- Function independently ; Maintain professional autonomy
- One profession may be dominant hold more power to determine the direction of care and professionals involved in the care plan

EG:

# Interdisciplinary teams

- Different health professionals working together
- Shared and overlapping goals for client/patient
- Maintain professional autonomy
- One profession may be dominant- hold more power for the purposes of decision making

EG:

# Transdisciplinary teams

- Health professionals have overlapping goals and responsibilities
- Different health professionals
- Mutual goals for clients/patients
- Share the tasks and responsibilities of each discipline. Equal status
- No professional dominance, equal power.

EG:

# For next class

- Reading #2
- Come up with an example for each 'team type'

# HS 2045

Class #2: PHC and Teams

Oct 2, 2013

# What's in the news?

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EG:

# IPC = Interprofessional Primary Care

- Like interdisciplinary + parts of transdisciplinary
  - “group of professionals from different disciplines who communicate and work together in a formal arrangement to care for a patient population in a PC setting”
  - “still not working optimally”
- 
- **What does it mean to work optimally?**

# IPC Reading... a Need for:

- better use of information
- better communication technology
- Improved monitoring and evaluation
- Appropriate funding models
- Greater levels of trust
- Incentives for individuals to work effectively in teams

# Barriers

## Individual Level

- Lack of clarity in roles and tasks ( > which inhibits trust)
- Perc'd and projected hierarchies

## Practice Level

- Lack of governance and leadership
- Right mix of skills and size
- Lack of physical space and time
- Inadequate communication structures

# Barriers

## System Level

- Lack of training in working in teams
- Funding models (blended FFS + salary)
- Extra incentives for physicians ... but who is doing the 'extra' work or drawing the 'extra' patients

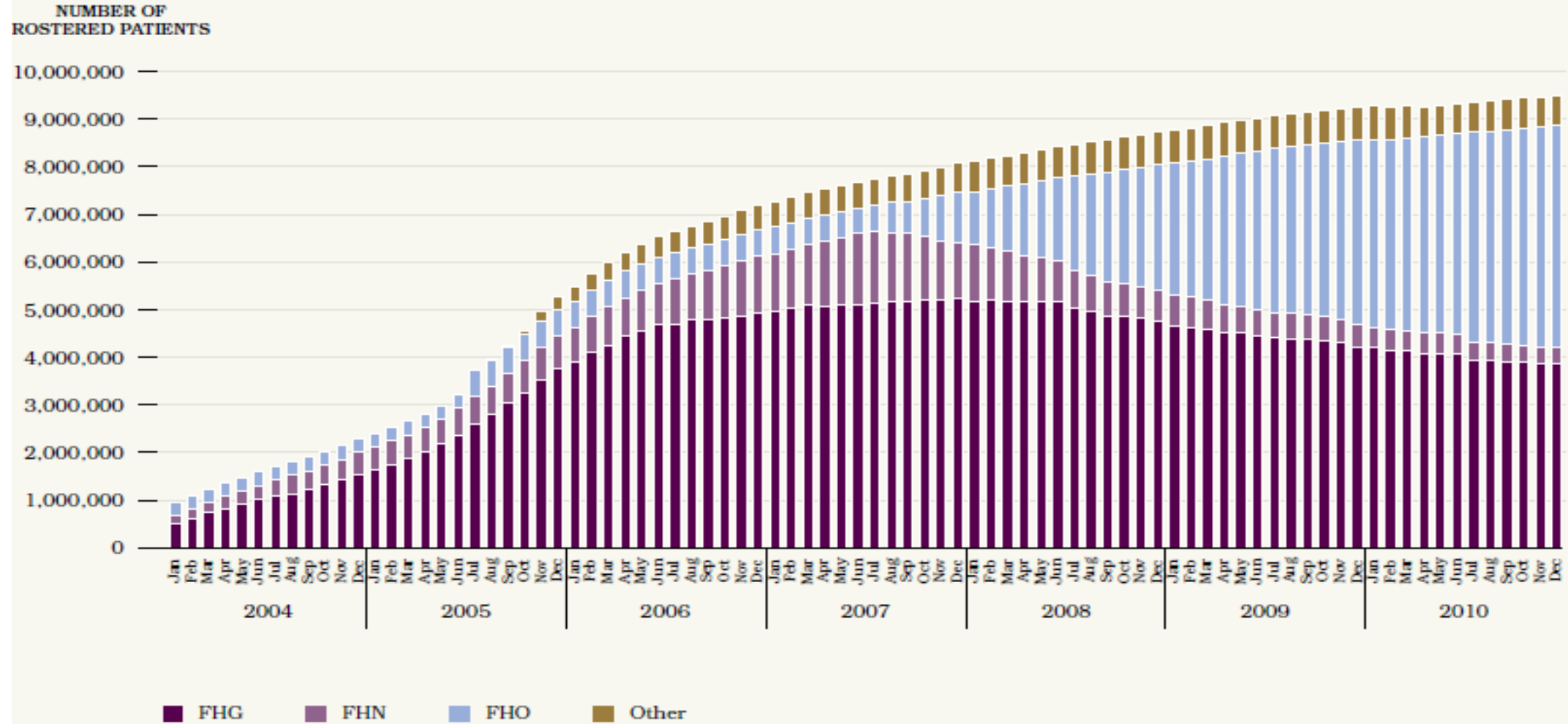
# What is effective teamwork in HC?

# Models of PHC Teams

1. FHT: interdisc; docs + allied HCP
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# Patient Enrolment

EXHIBIT 2 Number of rostered patients in different primary care payment models in Ontario\* (excluding Community Health Centres), 2004 to 2010



# Patient Enrolment Requirements

- seek treatment from their FHN family doctor first, unless they are travelling or find themselves in an emergency situation
- allow the Ministry to provide their doctor with information about services they have received from family doctors outside of the network and some preventive services
- not switch the doctor they're enrolled with more than twice per year

# Why teams?

- **Primary care** renewal has been identified as one of the province's transformation priorities
  - (Recall PRIMARY HEALTH CARE REFORM is a federal goal)
- A key priority of health system transformation is the establishment of Family Health Teams (FHTs)

# FHN

- A group of at least 5 family doctors working together with other health care professionals to provide accessible, coordinated care to enrolled patients
- After-hours care through a combination of on-call arrangements and a telephone health advisory service
- A new method of physician payment
- Voluntary for all patients and physicians

# FHGs

- Minimum of 3 physicians
- Comprehensive care to Ministry-supplied roster and to “registered” patients
- Fee-for-service (FFS) billing
- 10% increase to 13 most common GP codes
- Additional premium payments
- After hours services
- Patient registration (enrolment)
- Telephone Health Advisory Services (THAS)
- All payments directly to individual physicians in the FHG

# FHTs

- Build on existing models (FHN and FHGs)
- Provide a comprehensive range of health care services including case management,
- Expand access to primary health care,
- Support the management of chronic diseases
- Provide health information to enable patients to make informed decisions on self care,
- Emphasize education and disease prevention.
- “navigate” through the system

# FHT services

- Extended hours
- Home visits
- On-call
- Telephone h advisory services
- Optional lab services
- Optional day surgeries & diagnostics

# FHTs are NOT a funding model....

- The others (FHG, FHN, FHO) are.

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Class #3: Teams Cont'd

October 4, 2013

# Plan

- Today: finish teams
- Next week: start Cloud Medicine and technology
- Monday: talk about assignment

# FHT Governance

- ***Community Based*** are required to be incorporated non-profit organizations with community representation on the board of directors.
- ***Provider Based*** can be corporations, partnerships or professional associations or individual providers coming together through a contract of association.
- ***Mix of Provider and Community***

## To date...

- Since April 2005, 170 FHTs have been created in both urban and rural parts of the province.
- 50 more planned

# Rural-Northern Physician Grp Agreement

existed for a long time because not a lot of physicians in these areas

- The RNPGA
- serves rural and northern communities with a complement of one to seven physicians.
- group of physicians provide comprehensive primary health care services during regular and extended office hours.
- emergency services are provided 24/7 and patients have access to a nurse-staffed Telephone Health Advisory Service.
- Like all other primary care models, RNPGA physicians also emphasize illness prevention for their enrolled patients.

# Community Health Centres

- more population focused as opposed to family health teams and networks who follow the biomedical model  
more and patient focussed

- teams of physicians, nurse practitioners, nurses, counsellors, community workers and dieticians
  - serve high-risk communities and populations who may have trouble accessing health services because of language, culture, physical disabilities, socioeconomic status or geographic isolation.
  - focus on addressing the underlying conditions that affect people's health, such as poor diet, poverty, housing problems, violence and lack of education.
  - improve access to primary care and help strengthen communities.
- doctors are salaried by the lthins no ffs

# NP-led clinic

- over the next 4 years, 25 Nurse Practitioner-Led (NP-Led) Clinics, in 2 waves
  - Wave 1 Rural, Northern, Remote (SSM, EStC)
- must have at least one Registered Nurse in the Extended Class,
- access to physician services for out of scope NP services and consultation and collaboration, and include at least one of the following interdisciplinary health care providers:
  - Registered Nurse; Registered Practical Nurse; Pharmacist; Mental Health Worker; Social Worker; and/or Dietician.
- Salaries predominant method of compensation
  - in order to be funded they have to consult with physicians
  - can prescribe some medications

# Funding

fin fig or foh

- blended means ffs plus something else, physicians aren't paid under an fht funding model but all other healthcare workers are
- for physicians in FHTs can be by way of one of three blended models:
  - blended capitation, blended salary or blended complement
- Physicians also get 'incentive' payments for certain populations
- other members of the team receive salaries.
- [http://www.healthforceontario.ca/en/Home/Physicians/Training %7C Practising in Ontario/Physician Roles/Family Practice Models/Family Practice Compensation Models](http://www.healthforceontario.ca/en/Home/Physicians/Training_%7C_Practising_in_Ontario/Physician_Roles/Family_Practice_Models/Family_Practice_Compensation_Models)

capitation- for serving a certain number of people for example a diabetic kind of like a quota

accountability agreement- i will do this if you pay me this  
 community health centers dont have to have formal enrolment  
 but all others have to  
 loss of bonus payment- incentive to keep their same  
 patients

**EXHIBIT 1 Selected characteristics of primary care funding models in Ontario**

	PRIMARY CARE FUNDING MODEL*			
	Community Health Centre (CHC)	Family Health Group (FHG)	Family Health Network (FHN)	Family Health Organization (FHO)
PHYSICIAN REIMBURSEMENT	Salary	Blended fee for service	Blended capitation	Blended capitation
GOVERNANCE	Community board	Physician-led	Physician-led	Physician-led
AFTER-HOURS REQUIREMENTS	Yes	Yes	Yes	Yes
ACCOUNTABILITY AGREEMENT WITH LOCAL HEALTH INTEGRATION NETWORK	Yes	No	No	No
FORMAL ENROLMENT	No	Yes	Yes	Yes
COMMUNITY OUTREACH AND HEALTH PROMOTION SERVICES	Yes	No	No	No
LOSS OF BONUS PAYMENT FOR OUTSIDE PRIMARY CARE USE	No	No	Yes	Yes

# FHN Payment Overview

## ***Blended Model:***

**Capitation**

**+ fee-for-service**

**+ lump sum payments**

**+ special premiums**

**= blended model**

*Blended approach allows FHN physicians to receive an increase in remuneration if providing broad-based comprehensive care*

# Payment Overview

- Base payment rate determined by age and sex of patient
- Annual payment of \$102.00 per patient
- Some payments are made to individual physicians, but most are made to the FHN
- Bonuses for achieving preventive targets
  - on average a physician has 800-1200 patients
- Fee-for-service payments for core services (10%)
- Fee-for-service for excluded services
- Premiums for obstetrics, palliative care, house calls
- New patient fee; after hours fee; plus several additional enhancements

# Incentives/Bonuses

***Continuing Medical Education (CME):*** Maximum payment of \$2,400 per year per physician

***Access Bonus:*** Approximately \$20.00 per rostered patient; Every six months

***Group management and leadership payment:*** Payment of \$1.00 per patient per year

***THAS on-call payment:*** \$2,000 per FHN per month

***Preventive care bonuses:*** Up to \$11,000 per year for achieving high compliance levels for preventive care to rostered patients

# FHGs - Payment

don't have to know the difference between each group's premiums just know that they exist

## ***Senior Care Premium***

- 10% premium for General Assessment (A003) to registered patients aged 64 - 75
- Code Q065 claimable once per eligible patient per fiscal year

## ***After Hours Premium***

- 10% premium on all "after hours" assessments ("A" codes) to registered patients
- Paid via Q012 code

# FHGs - Payment (continued)

## ***Palliative Care Premium***

- \$2,000 for palliative care (code K023) for 4 or more patients per fiscal year
- Applies to patients on initial roster and to registered patients

## ***Mental Illness Care Premium***

- \$1,000 per fiscal year for 5 to 9 registered patients with bipolar disorder or schizophrenia
- \$2,000 per fiscal year for 10 more such patients

# FHGs - Payment (continued)

## ***New Patient Fee***

- \$100 each for up to 50 “new” (i.e. orphan) patients per fiscal year
  - \$110 for such patients aged 65 to 74; \$120 for ages 75 and over
  - Doctor and patient sign declaration confirming “orphan” status

# What makes an effective team? (Reading #3)

- We already knew this: concept of team is broad
- Explicit decision by team members to 'do it' (to collaborate)
  - Give up autonomy (recall 'loss' from Bridges)
- WW (nothing)

# Some assumptions

- Assumed teams are already in place
  - Formal or informal; patient centered (or self-) defined team exists
  - Who is 'your' team (doc, dentist, PT)
- Teamwork  $\neq$  collaboration
  - Instead interprof collaboration is a process affecting and a function of teamwork

# And why do we do it?

- What are the benefits? (see pg 29, we have talked about all of these)
- Happier and healthier workforce... that's good!
  - healthcare providers having a happy and healthy work environment

# The barriers

- Hierarchical culture of healthcare
  - Turf wars, historical power
- Self-regulation - not every profession is regulated
- Malpractice
  - Culture of blame; individual focus
  - Somebody takes the fall ... often the doc
- Financial incentives (or lack thereof)
  - Project based (vs System based) funding
    - dealing things on case by case vs looking at the big picture looking at the future, system base is harder

# Facilitators ...let's get it done. HOW?

- Leadership
- Clarity of roles
- Trust, respect
- Cultural readiness; culture of acceptance
  - Wait a minute... I thought culture came AFTER? (Kotter)
- EHRs
  - *“While they were sympathetic to concerns about privacy and confidentiality,... expanded access to pt information through electronic h records as a major facilitator of collaborative practice”*

# Collective Competence... good idea eh?

- <http://www.youtube.com/watch?v=vl-hifp4u40>

# Blog for This week

- Opens Friday
- Closes Wednesday
- You now know many things about TEAMS in HC. So – are they worth it? That’s your first decision (simple, yes or no, and justify). Next tell us how we do it. With so many barriers and facilitators – where do we focus our time and money: do we promote the facilitators, do we address the barriers... and no, we cannot just put more money into it to fix it”

# Readings for Week #5 (Oct 7-11)

- Monday:
  - Link to health affairs
- Wednesday
  - Greenhalgh paper (LONG, meaty, ... skim it... )
- Friday: NO CLASS, your task is to meet with your group, come up with a topic – and post it. Post it, talk about why you think it is an important challenge, and how you are going to ‘investigate it’. This post will also be your participation mark for the week.