

Grassroots Development of Interprofessional Primary Care Teams in Canada





Six million Canadians do not have access to a family doctor.* Despite calls for interprofessional teams to improve access, the widespread adoption and uptake of well-resourced team-based care in Canada is incomplete. In the absence of systemic supports and explicit directives from governments, there are only select family practices that have organized into teams aligned with College of Family Physicians of Canada (CFPC)'s Patient's Medical Home (PMH) vision. Based on a review of 17 such grassroots practices, the following were identified.



Essentials for grassroots transformation to team-based practice



Funds: Secure financial support through self-investment, and/or government and community funding.



Electronic medical records (EMRs):

Connect health team members through EMRs.



A champion: Designate a champion with vision, passion, and dedication to team-based care, to lead the transformation.



Partnerships: Establish partnerships of diverse expertise-including physicians, nurses, other care team members, and patients-to determine the needs of the community and to help co-design the PMH practice.

Key processes for grassroots transformation to team-based practice



Needs assessment and strategic planning: Identify community needs by analyzing relevant population reports and literature, and via community engagement.



Business case development: Outline the current state of the practice, describe the proposed change, and justify the request for resources.



Change management: Train team members, foster buy-in, and boost morale.



Continuous quality improvement: Continuously collect and analyze feedback and outcome data from within the practice and the broader community that it serves and apply necessary adjustments.

^{*}OurCare, https://www.ourcare.ca

Grassroots practices described the shift as leading to ...

Improved access:

"So, we saw double the number of patients, and we also saw, of course, more than double the number of revisits. So, we could see that through our stats that were reaching more people." (Participant 20)

"So that expanded my attachment as well, so I could take on more patients than I could by myself. But not only that, I could provide timely access through the physician assistant." (Participant 21)

Additional analysis of health administrative data found that grassroots practices in Ontario benefited with greater numbers of attached patients per physician, and annual patient visits per physician (in total; for individuals with chronic conditions), compared to family health team clinics and non-team-based family practices.

	Ontario: Grassroots team-based practices	Ontario: Team-based practices (non-grassroots)	Ontario: Non-team-based practices
Rostered patients per physician	1,371	1,228	587
Annual patient visits per physician	2,792	2,321	1,378
Annual visits by patients with chronic conditions per physician	935	725	385

Data source: ICES AHRQ Project Po908.104.000

Improved team collaboration and job satisfaction:

Family physicians experienced enhanced job satisfaction and less burnout. Indications of greater organizational efficiency and collaborative relationships were fostered, which enabled sharing knowledge across disciplines.

Improved health services use: Recruitment of physicians improved, practices expanded, and there was better integration with community services and specialized programs. Overall efficiency improved, including cost savings and reduced visits to local emergency departments.

"... our clients were going 39 per cent less often to the hospital for ER services than other clients in the province." (Participant 1, describing the beneficial impact of PMH practice at their clinic)

Recommendations for all levels of government

- Prioritize flexible and reliable funding opportunities for team-based transformation, fostering provider autonomy as they implement PMH practices
- 2. Establish clear and accessible processes for submitting business cases, which include support funding and operational supports
- 3. Pair pilot initiatives with comprehensive monitoring and evaluation systems that assess the impacts of transformations on primary care practices and patients



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