



# Team Development in PHC

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PRINCE EDWARD  
FAMILY HEALTH TEAM

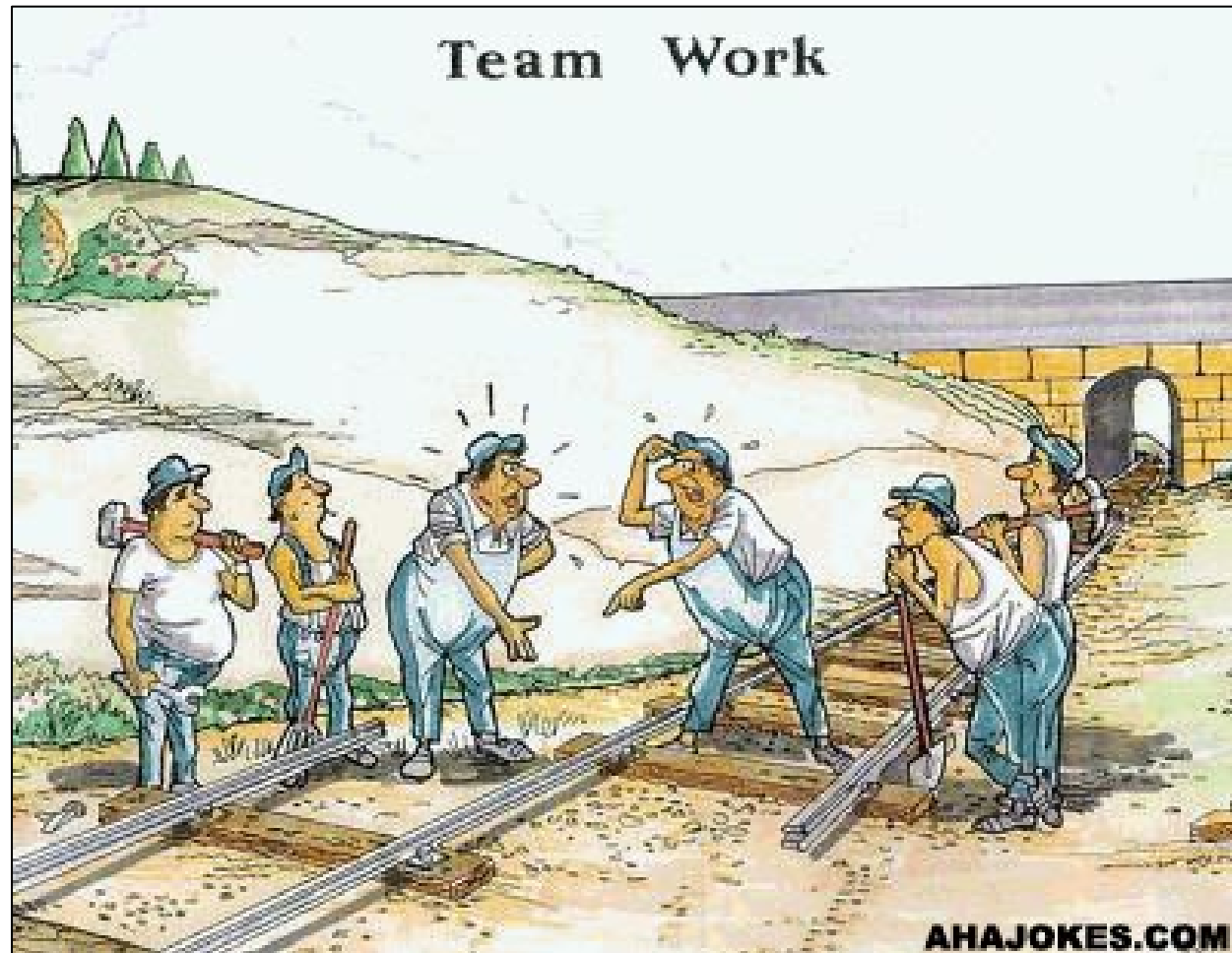




# Purpose

- To provide the theoretical literature and framework in team development; and
- To demonstrate the application by the Prince Edward Family Health Team

# WHY?





# Driving forces of change & team based care

- Demographics of aging population and related increase in chronic disease stats
  - “Requires effective prevention & management”
- Shortage of health care professionals
  - Necessitating optimal use of what we do have
- Escalating costs of delivering care
  - Cannot keep focusing funding on hospitals and specialist care
- Expectations: one single profession cannot deliver PHC in isolation



# National initiative on PHC reform and team-based care

- Romanow
- IECPCP
- PHCTF provincial envelope
- Ontario's vision for PHC – a focus on FHTs and CHCs



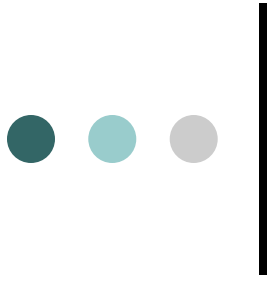
# MOHLTC vision of FHT model

- Family Health Team model in Ontario
  - 150 designated
  - Wave 1: Prince Edward FHT in Picton, Ontario
- Ministry's Vision and Goals
  - Access; quality; model of PHC
  - Improve access to care; enhance services; provide linkages
- Principles: Interprofessional Teams; Collaboration & Coordination of Care
  - within the FHT & with specialty services
  - with other sectors and
  - with community partners



# Steps to Team Development

- Shared vision and common goals
- Determine needs of population
- Determine the most appropriate health care providers required to meet the needs
- Plan, implement, and develop the team
- Evaluate



# The Prince Edward FHT



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# The Prince Edward Family Health Team Goals (2006)

1. To provide every resident of Prince Edward County with access to comprehensive primary healthcare
2. To expand and enhance the integrated delivery of health services to the Prince Edward community
3. To create a Centre of Excellence for rural health care



# Vision and Philosophy of care

- No resident of the County will be without access to PHC
- PHC will be delivered by an interprofessional team

# ● ● ● | Steps to Team Development

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- Evaluate the whole damned thing!



# Demographics & need for services

	Ontario	PE County
Median Age	37.2	44.3
% over 65	12.9	20.4
Unattached	?	14%



# PEFHT: Planning of new services

- Accept all applicants for rostering
  - Up to 600 new patients for each NP/FP team
- Public Health Program
- Mental health programs
  - incl Geriatric MH
- Chronic disease management: asthma; COPD; OA; osteoporosis
- Diabetes
- Palliative Care

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## Original FHN team

- 21 physicians
- family practice nurses
- office administrative staff
  
- sought care outside the team as appropriate – complex and ad hoc



# PEFHT: New team

- 26,000 residents/ 17,000 rostered to date
- 23 family physicians (full & part-time)
- 3 NPs
- 6 RNs
- 1 RT
- 1 MSW/ Mental Health Program Coordinator
- 1 PHN seconded from Health Unit
- 3 CCAC nurses on-site
- Specialist care: (psychiatry; int medicine; neurology)
  - on sessionals; or FFS
- 6 Admin staff and Executive Director

# ● ● ● | Steps to Team Development

- Shared philosophy of care
- Shared vision and common goals
- Determine needs of population
- Determine the most appropriate health care providers required to meet the needs
- **Plan, implement, and develop the team**
- Evaluate the process and the outcomes and refine as required



# Challenges with team implementation

- Space – offices geographically scattered
- Space- inadequate space to house everyone
- Space- team growth faster than new space creation
- Space lack of co-located HCP- creates inefficiencies
- FHN vs FHT funding: impact on team development
- EMR system –start up frustrations
- Inadequate time & energy to meet as a team
- Design of CDM models uncertain- still evolving



# Strengths supporting team development

## ○ People

- remain dedicated; committed to success
- strong leadership within the FHT
- shared –governance model
- caliber of team members hired

## ○ Partnership with Queen's University

- Commitment to teaching /IPE

## ○ Ministry and LHIN support

- for interprofessional education & practice

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# Evaluation: the current status

- Patient Care/ collecting stats
  - Additional rosters
  - Initial patient feedback very positive
  - CDM programs: COPD; CHF; MH; diabetes; asthma
- Team development; collaborative model
  - Team growth is rapid; team(s) are still evolving
  - Space a huge barrier to integration of clinicians & CDM services
  - People are our most valued resource
  - Program evaluation needed



# What does the literature say?



# Working in a Team

The team relies on collective contributions, comes together to solve problems and make decisions to improve the team's work and group performance, and members share a common purpose and goals and hold themselves mutually accountable for results

(Manion, J., Lorimer, W., Leander, W. J. [1996] Team based health care organizations: Blueprint for success. Gaithersburg, MD: Aspen, page 7)



# Patients perspectives

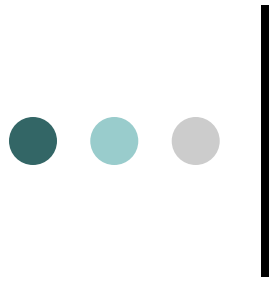
- Access to services
- Interactions with physician
- Interactions with other health care providers
- Personal self-responsibility
- Communication
  - Nair, Dolovich, Ciliska, & Lee Family Medicine 2006



# Interdisciplinary Work

Interdisciplinary work requires a certain degree of intellectual fortitude...We must attempt a bit of intellectual daring and, above all, we have to be prepared to listen and learn from each others, showing mutual tolerance and acceptance in doing so.

(Polkinghorne, J [1998] *Belief in God in an Age of Science*. New Haven CT: Yale University Press page 83)



# Collaborative Relationships

A collaborative relationship cannot develop if individuals do not respect each others' competencies

(Chaboyer, W. P., & Patterson, E.[2001] Australian hospital generalist and critical care nurses' perceptions of doctor-nurse collaboration. Nursing and Health Sciences, 3, 73-79 page 74)



# Collaboration

Joint communication and decision-making process with the goal of satisfying the patient's wellness and illness needs while respecting the unique qualities and abilities of each professional.

(Coluccio, M., & Maguire, P. [1983]. Collaborative practice: becoming a reality through primary nursing. *Nursing Administration Quarterly*, 7, 59-63.)



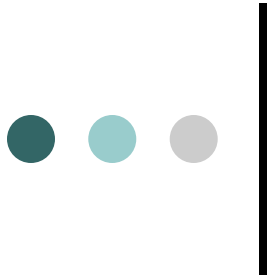
# Effective Collaboration

- Open, honest communication
- Mutual trust
- Respect
- Understanding and valuing each other's perspective and way of thinking
- Familiarity with and valuing each other's style and scope of practice
- Equality and shared power
- Professional competence
- Shared responsibility and accountability
- Shared decision making
- Shared values, goals and visions
- Willingness to openly discuss differences
- Willingness to share information
- Unified front and mutual support
- Willingness to devote time and energy to the relationship
- Frank discussion of financial issues (MCP<sup>2</sup> project)



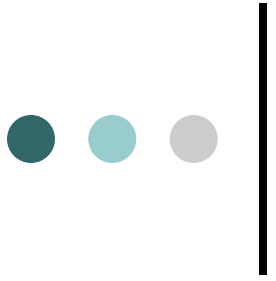
# Barriers and challenges to collaboration

- Different education preparation – don't understand each other
- Different financial incentive structures
- Hierarchical health care system
- Traditional independence of medical practice
- Differences in social status – power differential
- Gender issues
- Satisfying professional autonomy. (MCP<sup>2</sup> project)

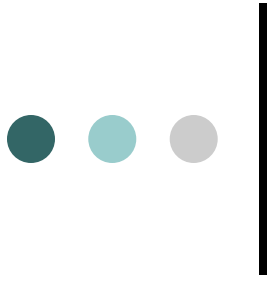


# Six sequential stages towards collaborative practice:

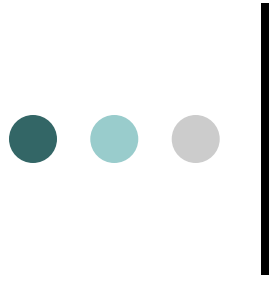
1. Communication: ad hoc or planned sharing of information.
2. Consultation: communication in which one party seeks direction from another.
3. Cooperation: a short-term informal relationship that exists without clearly defined mission statements, structures or plans.
4. Coordination: a more formal relationship that has a shared mission and more formal structure and planning arrangements.
5. Collaboration: a process in which those parties with a stake in the problem activity seek a mutually determined solution.
6. Collaborative practice: a highly structured form of continuing collaboration among members of an interdisciplinary team for communication and decision making



# Collaboration works...



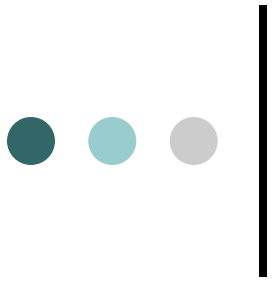
...but cannot be mandated.



“ collaboration... requires hard work and an investment in time to develop and maintain”



“...occurs between individuals and only the persons involved ultimately determine whether or not collaboration occurs”



?



Interactive workshop: what do you have to say?



# Strategy to building a team

- Is desire & willingness to collaborate and build a highly effective, collaborative team essential?
  - Is it sometimes a false assumption?
- Which elements are most critical?
  - Exemplary leadership skill ?
  - & team development process?
  - Commitment to the process ?
  - Determination to overcome the challenges?
  - Having a process for conflict resolution?
  - Knowledge of and application of change management theory ?



# Next Steps in Team Development

- To remove the barriers to enhancing teams?
- Identify the largest barriers to good team development:
  - Attitudes of providers and patients?
  - Infrastructure-?
  - Time
  - MOHLTC policy /inequities?
  - Inadequate knowledge of service delivery models for CDM programs?



# Next Steps in Team Development

- How can the South East LHIN support us in developing our teams?



## Evaluation

Has this session on team development been useful?

If so, should we have a follow up session?

How often? How?