THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

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## Executive Summary

# Interprofessional Primary Care Teams: A literature review of potential international best practices

High-performing primary care is widely recognized as the foundation of an effective and efficient health care system. Countries with a robust primary care sector achieve superior health outcomes at lower costs. Over the past two decades, Canadian provinces and territories have introduced primary care reform initiatives that focus on strengthening the infrastructure for primary care and establishing funding and payment models that promote performance improvement. Despite this progress, the performance of Canadian primary care trails that of many other high-income countries in access to regular doctors or places of care, timely access to care, development of interprofessional teams, and communication across health care settings.

Implementing interprofessional teams is a key feature of high-performing primary care systems. In Canada, several jurisdictions have introduced team-based models, all of which vary significantly in terms of their structure, physician reimbursement scheme, types of primary care providers, governance mechanisms, funding mechanism for primary care providers, enrolment of patients, scope of services, nature of the population being served, and the adoption of a population-based approach to planning and delivering care. Despite significant investments in building interprofessional teams, there is limited evidence that current team models are producing consistently better results in relation to the quadruple aim (improving population health, reducing the cost of care, enhancing patient experience, and improving provider satisfaction). Thus, the objective of this study was to identify potential international best practices in relation to interprofessional primary care teams.* The findings were informed by a rapid literature review of the grey and scientific literature in multiple databases.

This literature review found 28 potential best practices. The majority of the best practices were from the United States. Other jurisdictions included Sweden, Nepal, Singapore, Hong Kong, and Australia. These best practices ranged from health centres, academic medical centres, private practices, to integrated delivery systems or programs.

To identify the characteristics that were most common to potential best practices, Aggarwal and Hutchison's framework on the attributes of high-performing primary care systems and Boden-

* For instance, Oak Street Health (Section 4.1) in the United States is considered a "best practice." For the purposes of this paper, the term "best practice" does not refer to the most efficient and effective methods of administration or operation for a given practice.

heimer's work on the building blocks for high-performing teams were used. The features assessed included: engaged leadership, organizational governance, funding model, patient attachment, health information technology, population health management, care coordination, team composition, expanded scope of practice, comprehensive care services, performance measurement, quality improvement, patient engagement, prompt access to care, and continuity of care.

## Key Findings

This review found that a common feature of potential best practices was their focus on **providing care to various target populations**. This included those from low-income or uninsured groups, adults that were 65 and older, veterans or military personnel, children, or people with chronic conditions. In addition, several of the interprofessional teams were providing a **range of comprehensive services** that could include preventive care, chronic disease management, services and programs to address the social determinants of health, as well as providing dental, optometry, orthopedic, or behavioural health services. Further, many interprofessional teams consisted of a physician, nurse, and **a range of two or more diverse interprofessional providers.** Across all practices, 50 different team roles were identified. The most common roles included primary care physicians, nurses, behavioural integration specialists or social workers, and pharmacists. In some practices registered nurses, medical assistants, and/or panel managers were reported to be empowered and supported to **extend their scope of practice**.

**Timely access** to care was also a key feature of many best practices and was facilitated through various mechanisms including same-day appointments, third next available appointments, after-hours coverage, 24/7 access to providers, home visits, telehealth (phone, video visits), remote monitoring, telephone hotlines, or nurse triage lines, secure messaging, email, policies on patients being seen in a set period or number per day, and the use of forecasting tools to estimate demand. In some of the practices, patients were assigned to a provider to enable **continuity of care,** and care plans were being developed as a mechanism for engaging patients in their care.

Some practices were using **electronic medical records or health records**. Health information technology was being used for various purposes including care coordination, data-driven performance measurement, panel and population management, and managing patient visits. Some best practices reported initiatives for performance measurement and quality improvement. This included collecting **performance measurement data** using various mechanisms including dashboards and performance measurement frameworks. Some practices were involved in **quality improvement**, which was enabled through regular team meetings, establishment of performance metrics and targets, practice facilitators, and workflow mapping.

Although each best practice is different in terms of context and organization, available evidence indicates that interprofessional teams positively impact the goals of the quadruple aim. Some evaluations of best practices found they improved patient and family satisfaction, reduced hospitalizations, generated cost savings, and improved patient outcomes (improvement in geriatric depression and diabetes, alleviating severity in continence, reducing cardiovascular disease and mortality, and enhanced equity for migrant populations). Self-reported data from best practice organizations also reported reductions in hospital admissions, emergency room visits, number of in-patient hospital days, and no-show rates. Providing more accessible care in rural communities and improving team functioning were areas that required further improvement.

Many of the characteristics of the identified best practices are part of the College of Family Physicians of Canada™ (CFPC)'s Patient's Medical Home (PMH) vision. When comparing interprofessional models across Canada, the best practices identified in this review resembled Ontario's Community Health Centre model, which focuses on the delivery of a

wide array of comprehensive services by a range of health care professionals to marginalized and vulnerable populations. However, it is essential to note there was a lack of information on the leadership approach, governance framework, funding models, and accountability mechanisms for best practices. In addition, there was limited evidence of impact on the barriers and facilitators to implementation. These findings are not surprising as the lack of primary care research remains a challenge worldwide.

## Limitations

There are limitations to this review. First, despite best efforts, some relevant articles on potential best practices may have been missed. Since this was a global study, the language of documents was context specific. As such, information from these non-English language documents could not be included but could have provided more insights. Furthermore, there were varying degrees of information on each best practice. As such, this review could only report on available information. Some best practices may include common features that could not be identified through this review.

## Recommendations

As the CFPC continues to advocate for the patient medical home vision in Canada, it is recommended that:

- The CFPC conduct further research on identified international potential best practices to obtain more details on the attributes of high-performing teams and explore their leadership approach, governance framework, funding model, accountability mechanisms, and barriers and facilitators to their implementation.
- The CFPC advocate provincial, territorial, and federal governments to invest in interprofessional team models that require the implementation and accountability of the characteristics of high-performing best practices identified in this study.
- The CFPC advocate provincial, territorial, and federal governments to invest in evaluating and conducting research on existing interprofessional team models to determine how they can be optimized and spread across Canada.

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For supporting references, please refer to the full report *Interprofessional Primary Care Teams: A literature review of potential international best practices.*