PRIMARY CARE TRANSFORMATION

A collaborative practice tool kit

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Doctors Nova Scotia

Contents

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Collaboration needs to come outside of the four walls of each physician's workspace or clinic; it is important for physicians to reach out to other physicians and providers.
– Dr. Holly Zwicker, Crossroads Family Practice

Disclaimer: It is important to remember that there is no one-size-fits-all approach to providing primary care. Physicians, patients and communities throughout Nova Scotia require flexibility in how they deliver and receive care. In some cases, a solo family practice as part of a larger network might best meet a community's needs; in other areas, a collaborative team may best serve a population. In some instances, a patient may only want to receive care from their family physician, while others may prefer accessing the expertise of multiple providers. The health-care system needs to allow for these variations in practice types.

Introduction

This tool kit was created to support physicians who are considering collaborative practice and to help them have informed conversations with the Nova Scotia Health Authority (NSHA) about creating this type of practice.

The tool kit was developed based on a thorough literature review and environmental scan of collaborative care. It is informed by interviews with key stakeholders in Nova Scotia and across Canada, as well as in-depth case studies of three collaborative practices in the province. The tool kit has five sections:

- Collaborative Practice: Meaning, Models, Benefits and Challenges
- Payment Models
- Structural Considerations
- Providing Care as a Collaborative Team
- Liability Issues

HOW TO USE THIS TOOL KIT

You may choose to read this tool kit from cover to cover, or you might pick and choose, reading only the chapter that answers your specific questions.

Each section contains practical information from the literature, examples from collaborative practices in Nova Scotia, insights from the experiences of Nova Scotia doctors, implications for collaborative practice, a set of critical reflection questions for doctors to consider, and suggested tools and resources you may consult for further information.

The appendix includes a selection of resources that may be helpful for you and your colleagues as you consider transforming your practice to a collaborative care team, including contract templates and literature for patients.

Meaningful change is possible. In the midst of chaos in health care, we get tired and at times disillusioned, but new opportunities arise from such chaos. We are perfectly poised for collaboration and transformation.
–Dr. Maria Patriquin, Living Well Integrative Health Center

Collaborative Practice:

Meaning, Models, Benefits and Challenges

THIS SECTION'S
Key Concepts

- Meaning of collaborative care and the "health home" model
- Models for collaborative practice proposed by the NSHA
- Benefits and challenges of collaborative practice

The Meaning of Collaborative Care

There are many definitions of collaborative care, all of which include a range of integrative health professionals coming together to provide comprehensive health care. Other terms often used are multidisciplinary or interdisciplinary care, inter-professional care and team care. The Enhancing Interdisciplinary Collaboration in Primary Health Care Initiative offers the following working definition:

> *Interdisciplinary collaboration refers to the positive interaction of two or more health professionals, who bring their unique skills and knowledge, to assist patients/clients and families with their health decisions. (Nolte, 2005)*

WORDS OF WISDOM

Dr. Caroline Hancock

Annapolis Collaborative Practice

I would stress that our model has grown gradually to fit our needs and facilities. It is still evolving and improving. The key elements that have made our team successful – collegiality, respect and mutual responsibility – can be built in any setting.

The Health Home Model

The Nova Scotia Health Authority (NSHA) is adopting a "health home" model for delivering primary care. It is based on the College of Family Physicians of Canada's (CFPC) Patient's Medical Home (PMH), which it defines as:

> *…the central hub for the timely provision and coordination of a comprehensive menu of health and medical services patients need…. It is where patient-doctor, patient-nurse and other therapeutic relationships are developed and strengthened over time, enabling the best possible health outcomes for each person, the practice population and the community being served. (CFPC, 2011, p.8)*

THE 10 PILLARS OF THE PMH ARE:

1. Providing patient-centred care
2. Ensuring every patient has a personal family physician
3. Providing a broad scope of services, carried out by teams or networks of providers
4. Ensuring timely access to appointments in the practice and advocacy for timely appointments with other services needed outside the practice
5. Providing a comprehensive scope of family practice services that also meet population and public health needs
6. Improving continuity of care, relationships and information for patients
7. Maintaining electronic medical records (EMRs) for patients
8. Training medical students, family medicine residents and those in other health professions
9. Evaluating the effectiveness of the PMH in continuous quality improvements
10. Working within governance and management structures defined by stakeholders such as government, patients, the public, and other medical and health professions and their organizations across Canada (CFPC, 2011)

In Nova Scotia, health homes are being organized by location. The NSHA suggests that community clusters be formed based on population size and primary care services, and networks (groups of community clusters) cover a broader geography/population base, integrate community-based services, and provide specialized programs and supports (Primary Health Care, NSHA, 2017).

Health homes are operated by collaborative family practice teams. These teams include family physicians, nurse practitioners, family practice nurses, community team members (e.g., social workers, dietitians, occupational therapists, physiotherapists), aligned community pharmacists, clerical support and leadership/management support. Each team is responsible for office-based primary care, working with others to support community-based wellness, promoting prevention of disease, early diagnosis and intervention, and reducing/treating chronic disease. In response to community and practice needs, physicians and other team members may be required to include hospital care, home visits, emergency room care and intra-partum care as part of their scope.

MODELS FOR COLLABORATIVE PRACTICES

In a series of focus groups the NSHA's Primary Care Services conducted in the fall of 2016 with family physicians and family medicine residents, participants suggested that physicians:

- Value autonomy, generally want to be involved in managing a practice (e.g., hiring and managing staff) and need support to do this
- Have concerns about potential challenges with collective agreements (e.g., they may not be able to hire staff they think are a fit with the practice, challenges with letting staff go who are not meeting expectations, problems with staff scheduling due to collective agreements)
- Feel a need to clarify roles and responsibilities in co-leadership models

The NSHA subsequently articulated three governance models for collaborative family practice teams to deliver primary care within the health home model in Nova Scotia:

- Contracted services governance model
- Co-leadership governance model
- Turn-key governance model

Contracted Services Governance Model

The contracted services governance model involves physician(s) or an entity setting up, managing and operating a practice. The NSHA flows funds through the entity/physician(s) to cover the costs of operating the collaborative family practice team, including team member compensation, operating expenses and infrastructure expenses. Start-up costs are provided in accordance with the new team members being added.

Potential pros

- Physicians are afforded more autonomy (e.g., control over schedule, input – along with the NSHA – about health professionals to be added to the practice) – this approach may appeal to physicians already working in the system and running their own practices
- May offer the easiest transition from a traditional practice to a collaborative practice because small changes can be made incrementally

Potential cons

- Expertise in managing a practice is needed; physicians do not necessarily have the expertise or time or desire to manage a practice
- Physicians must see all patients in order to be paid for service (assuming they are paid on a fee-for-service basis), not allowing others (e.g., nurse practitioners) to work to their full scope of practice
- If the payment model is fee for service, there may be a focus on volume of patients, leaving less time for each patient
- There may be concern about insufficient funding to encompass all aspects of practice management
- Communication and coordination may be challenging unless the practice utilizes an EMR
- Staff recruitment can be challenging

WORDS OF WISDOM

Dr. Holly Zwicker

Crossroads Family Practice

As it stands right now, when you are part of an APP contract, you are expected to meet certain criteria, and there are certain categories of activities you are expected to keep a log of and report on an annual basis. Knowing what those categories are so you can devise a system to keep track of them would be helpful.

Co-leadership Governance Model

In the co-leadership governance model, physicians share leadership of the practice with the NSHA and work alongside inter-professional team members, including family practice nurses, nurse practitioners and other community-adaptive team members (e.g., social workers, dietitians and others) who are employed directly by the NSHA. Physicians are responsible for operating the space and receive funding from the NSHA to contribute toward the operating costs for the team members working in the practice. Administrative staff members are typically hired by the entity/physician(s).

Potential pros

- This approach is flexible and can be tailored to individual practices and providers
- Respectful, trusting relationships between staff members and good communication with the NSHA are required for the practice to run smoothly
- If hired and paid by the NSHA, family practice nurses and nurse practitioners can work to their scopes of practice, which enables physicians to care for those patients whose needs can best be met by their expertise
- Team members with similar areas of expertise can provide cross-coverage for each other
- Salaries for other providers and are paid directly by the NSHA; the NSHA also contributes overhead costs for the providers working in the practice (including administrative support, rent and supplies)

Potential cons

- Expertise in managing a practice is needed; physicians do not necessarily have the expertise, time or desire to manage a practice
- Physicians may have less decision-making autonomy than in the contracted services model
- Because non-physician staff are hired and paid by the NSHA and are accountable to the NSHA, competing interests and loyalties could arise

Turn-key Governance Model

In the turn-key governance model, physicians and allied health providers are employees of the NSHA, working in a space that is either owned or leased and managed by the NSHA.

Potential pros

- Physicians do not manage the business; however, there are elements of co-leadership built into this model
- If and when possible, the NSHA teams work with the physicians in hiring staff
- Family practice nurses and nurse practitioners can work to their scopes of practice, which enables physicians to care for those patients whose needs can best be met by their expertise

Potential cons

- Physicians have less autonomy and therefore may be less committed to the practice, less motivated and less committed to change

WORDS OF WISDOM

Dr. Michelle Dow

Clare Medical Centre

Just build your team and practice and it will evolve over time. Be flexible and change as you go – sometimes change can make your life a lot better. If you feel it's important, take responsibility and make it happen. Don't wait for the province – or anyone else – to make it happen.

PRACTICES MUST BE TAILORED TO THE COMMUNITY

Each community is different, and flexibility is required to ensure that any approach adopted meets the local community's needs and realities regarding how they deliver and receive care, while recognizing local resources and difference/variance in health care access.

Collaborative practice can look different in different communities, as well as within a practice. – Dr. Andrea McDonald, Duffus Health Centre

BENEFITS OF COLLABORATIVE PRACTICE

Physicians and key stakeholders in Nova Scotia and other provinces have identified several benefits of collaborative practice, which are also supported in the research (Baik, 2016; WHO, 2010):

- Physicians are able to share with and benefit from the perspectives/skills of interdisciplinary colleagues
- There is less duplication of services and more efficient use of resources (financial and human)
- Patients have more timely access to physicians and coordinated services
- Patients see appropriate health providers
- Patients have improved outcomes
- Physicians can offer patient-centred quality care; patients are supported and educated about their health
- Physicians experience a good quality of life and work/life balance
- Health-care professionals enjoy improved job satisfaction, productivity, retention, sustainability and quality of life

QUESTIONS *for Reflection*

1. When thinking about whether collaborative practice is right for you, consider these questions:
2. What am I looking for in a collaborative practice?
3. What needs and/or strengths has the community expressed?
4. Are there any barriers I would need to address for the practice to run smoothly?
5. What expertise do I have in managing a business? How could I access additional business management expertise if needed?
6. How much and what kind of autonomy do I want in my practice?
7. Is it important to me to hire and supervise my own staff, would I prefer to have the NSHA handle that, or would we do it together?
8. Do I anticipate staff requirements outside of normal working hours?
9. How much office space is required for a collaborative practice? Am I comfortable assuming the risks associated with that overhead?
10. What should be included in a contract between my collaborative practice and the NSHA?
11. What else do I need to know?

READY TO SIGN A CONTRACT? Have DNS review it first. Contact your Physician Advisor for assistance.

We work closely together. We can easily consult with each other when we want another perspective. We have a pot of funds that we decide how to allocate – we individually agree to supply a set number of hours per year. We have access to each other's patient lists and we take turns as the daily clinician. Our flexibility gives us a good quality of life and makes our practice sustainable. We can keep people here. – Dr. Simon Bonnington, Annapolis Collaborative Practice

CHALLENGES OF COLLABORATIVE PRACTICE

Physicians and key stakeholders in Nova Scotia and other provinces identified several challenges of collaborative practice, which are also supported in the research (Bishop et al., 2013; Kelly, D.V. et al, 2013; Nicholson et al., 2013; Valaitis, 2012):

- Current fee structures in Nova Scotia do not support collaboration
- Collaboration and relationship-building take time
- The costs of a collaborative model may be greater than other models in the short-term
- EMRs are costly and require training and continual updates, which can be disruptive to services
- There is a need for one consistent EMR system across the province
- The province lacks a shared, clear, consistent, stable provincial vision about primary care
- Differing priorities among health professionals
- Lack of understanding of interdisciplinary teamwork among physicians
- Resistance to change among late-career physicians
- Physician concern about the possibility of increased medico-legal liability

Collaboration is a process; changes must be small and incremental. When permitted input into the process, providers accept and commit to change more readily. Collaboration must be embraced as a "value-adding" practice. It requires huge investments of time, intellect and other resources, so physician buy-in and engagement is key. – Dr. Maria Patriquin, Living Well Integrative Health Centre

Crossroads Family Practice

Tantallon, N.S.

"This model of health-care delivery has the potential to provide better outcomes for patients and improve the efficiency of the system overall."

When Dr. Holly Zwicker and business partner Dr. Shauna Herman were setting up their medical practice, they knew exactly what they wanted.

"Our vision was to provide community care, and to provide really good access and a really good standard of care for our patients," said Dr. Zwicker.

The practice opened on Jan. 1, 2010. Nine years later, through a careful combination of hard work, collaborative care and technology, that vision has been realized. Now, Drs. Zwicker and Herman work with five other physicians, two family practice nurses (FPNs) and an administrative team. The clinic is also now a core teaching site with Dalhousie Medical School, and the physicians work with medical students and

first- and second-year residents.

"To us, collaborative care entails physicians and other providers using complementary skills, knowledge and competencies, working together to provide care to a common group of patients based on trust, respect and an understanding of each other's skills and knowledge," said Dr. Zwicker. "It has the potential to provide better outcomes for patients and improve the efficiency of the system overall."

Having FPNs on staff has made a huge difference in the practice, said Dr. Zwicker, especially in terms of ensuring patients have access to care.

"One of our nurses, Lori Bates, has appointments available every day. She heads our immunization program and does a lot of our well-baby and well-woman care, as well as non-insured services.

"Having her on hand to provide nursing care and take care of the task-oriented parts of patient care – things like immunizations and Pap tests – allows me to spend more time with my complex patients," said Dr. Zwicker.

"Natasha Terry, a more recent addition to the team, is in the midst of her Family Practice Nurse Training. She will help improve access for our patients and provide more structured follow-up for our patients with chronic diseases."

However, funding the FPN positions has been a challenge. "The nurse has to see enough patients to generate revenue that covers both the overhead and her salary," said Dr. Zwicker. "There isn't much left to compensate the physicians for the extra work they do in supervising a nurse and being responsible for the patients she sees."

Finding the right funding model has been an ongoing issue, with the clinic moving from fee-for-service (FFS) to alternative payment plans (APPs) in mid-2017.

"A few of our doctors had lessened the amount of time they were spending in their family practices to do more lucrative work in places like walk-in clinics, where there is less paperwork, less stress, less time-heavy work," said Dr. Zwicker. "They loved family medicine but left us for different payment models."

That trend seems to be reversing now that the clinic has moved to the APP model, with two physicians returning to the clinic and increasing their hours. After experiencing difficulties while trying to negotiate a group APP contract, the physicians each signed their own APP contract, but payments are made directly to

the clinic. Payments – less overhead costs – are then dispersed to the physicians through a regular payroll system.

The clinic's 5,000-square-foot office was designed by Drs. Zwicker and Herman and built to their specifications. It includes 13 examination rooms, a reception area and a waiting area, as well as a common room for staff, with a table and chairs as well as three computer work centres. "This is the nerve centre for physicians and staff," said Dr. Zwicker.

"The way our space is set up allows us to both formally and informally discuss how we are managing patients or groups of patients."

The practice continues to advance improvements in patient care – using their EMR to manage patients with specific health needs; adopting an online booking system; and pushing for funding to cover the work of their FPN. Looking ahead, the physicians hope to expand the practice to include other providers, such as a psychologist and a pediatrician.

"Working in a collaborative practice is just what I wanted it to be," said Dr. Zwicker. "Collaborative care results in a happier, better cared-for patient population."

Payment Models

THIS SECTION'S
Key Concepts

- Fee-for-service (FFS) payment model
- Alternative payment plan (APP) payment model
- Doctors Nova Scotia's proposed blended payment model for collaborative practices in Nova Scotia

WORDS OF WISDOM

Dr. Timothy Woodford

Queens Family Medicine

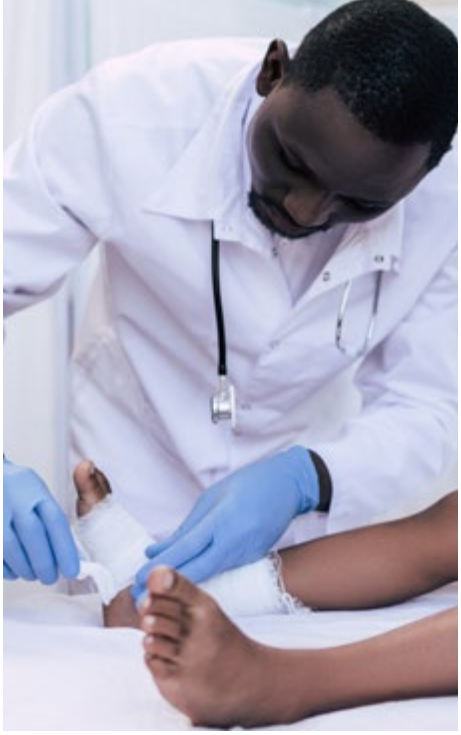
APPs aren't well designed for family doctors doing rural full-service medicine (office practice, ER coverage, nursing home coverage, inpatient care, palliative care, possibly obstetrics). Depending on your workload on any given week (e.g., on call in ER two or three times) it can be very difficult to meet the office-hour requirements. New doctors starting out with 500 new patients a year [and working] up to 1,200 over several years would likely be most attracted to this model. It doesn't make sense for doctors with large practices to switch over to this model the way it exists. The paid-leave clause is also misleading. Statutory holidays are not included. There are 10 or 11 of them in a year. This effectively leaves you with four weeks for vacation and educational leave.

Fee for Service

In the fee-for-service (FFS) model, physicians are self-employed professionals who bill for each individual service they provide. They are responsible for paying their staff and their overhead expenses (such as rent and office equipment) from the fees they receive (Canadian Medical Association, 2017).

Potential pros

- Remuneration is available to FFS physicians working in collaborative family practice teams
- Because FFS encourages volume, more patients tend to be served
- Physicians preserve autonomy over the nature of their practices and service delivery



Potential cons

- Under this payment structure, it may be challenging to make unpaid time available to collaborate with other providers
- The Fee Schedule does not reflect complex case management and collaboration
- Physicians are responsible for all overhead costs
- There is no compensation for time spent on administrative or collaborative work
- Physicians must see patients of other providers in the practice (such as family practice nurses or nurse practitioners) in order to bill for the visit; this can undermine the ability of other providers to work to their full scope of practice
- There is a risk of overuse of services and overtreatment of patients
- There may be a focus on volume, leaving less time for each patient
- A "one problem per visit" approach may be encouraged
- Physicians face continued exposure to billing audit risk and billing interpretation disputes
- Professional satisfaction may be decreased due to the challenges

Alternative Payment Plans

Alternative payment plans (APPs) are funding agreements for the provision of clinical services by an individual or group of physicians. An APP is a funding option for family physicians and some regional specialists.

All APP contracts must be agreed to and signed by the Department of Health and Wellness (DHW), the NSHA, DNS and the physician(s), and First Nations Bands where applicable. The contract specifies set levels of clinical, research and/or administrative activities and deliverables, as well as the amount of remuneration physicians will receive. APP contracts are designed to provide physicians with a guaranteed minimum funding level and income stability, provide government with cost-certainty, and facilitate the delivery of efficient and effective medical practice that may not be compatible with the fee-for-service funding model.

Typically, APP proposals and deliverables are developed collaboratively by the physician(s) and the NSHA Zone Medical Director/Zone Family Practice Department Head. In APPs, physicians, supported by DNS, work with the NSHA to develop a mechanism for tracking the deliverables, which are periodically compared to budgeted amounts. APPs require physicians to submit billings as though they were being compensated through an FFS model – this is referred to as shadow billing (Canadian Medical Association, 2017).

Physicians are encouraged to contact DNS prior to signing contracts or deliverable agreements with the NSHA or the DHW.

Physicians are required to submit a year-end activity report and a report detailing their absences from practice during the preceding year to the NSHA within 30 days of the end of each fiscal year. The year-end activity report is intended to record all of the services they provided that could not be shadow-billed.

Remuneration can be paid directly to an individual physician or to a group of physicians; in the latter case, income-sharing becomes another factor in the formula.

Potential pros

- Physicians have a guaranteed salary and a stable base salary
- There is a positive impact on rural recruitment and retention of physicians
- APPs work well for physicians in community health centres
- Physicians do not have to focus on the volume of patients they treat, so they can spend more time with patients in need
- APPs offer greater ability to allow all providers to work to their full scope of practice
- Physicians have a greater ability to provide services based on community need rather than business need (that is, physicians are less likely to need to prefer billable services over non-billable services)

Potential cons

- Reporting requirements take time and effort to manage
- Physicians will not typically see any increase in payment even when providing more services or serving larger numbers of patients (unlike in an FFS model)
- A continued focus on shadow-billing quotas undermines physicians' ability to provide care in innovative ways not captured by the Fee Schedule
- There is less autonomy for physicians, who must negotiate deliverables and practice structure with the NSHA
- Physicians face a continued exposure to audit risk and billing interpretation disputes
- APPs do not enhance patient attachment and continuity of care (unlike patient rostering in the blended payment model)

PATIENT ROSTERING

Patient rostering means that patients register with a family practice, family physician or team for their care. According to the CFPC (2012), rostering helps define the patient population, provides better access to information about each patient, supports optimal scheduling of visits, facilitates preventive care, enhances chronic disease management, and strengthens the patient–family physician team relationship. Doctors Nova Scotia recommends that patient rostering be implemented as part of a blended payment model for primary care.

Blended Payment Model

The blended payment model is not currently in place in Nova Scotia. Many provinces, such as New Brunswick, Ontario and Alberta, are exploring blended payment models or have already implemented them.

A blended payment model is a payment arrangement that combines aspects of different payment models, including capitation, FFS and salary (College of Family Physicians of Canada, 2016). Generally, blended payment models aim to use the best, and mitigate the worst, features of various funding models in an effort to better support physicians and patient care. For example, by using a blended payment model a funder can incent volume through FFS, while more time-consuming based care, such as chronic disease management, is incentivized through capitation or salary. In current payment models, it is challenging to balance patient volumes and patient care needs. Many blended payment models aim to support volume without creating a disincentive to provide chronic disease management and other time-intensive care.

CAPITATION

Capitation is when physicians are paid a fixed amount to provide care to a defined group of patients under their care. The remuneration unit is the individual patient, not a service or procedure. Capitation considers the importance of patient-centred care and the fact that patients have differing health needs; remuneration for patients varies, depending on predetermined factors (such as age and sex). Capitation guarantees an annual basic fee for each rostered patient for the delivery of a predetermined set of services. The payments are made in 12 equal installments, regardless of whether the physician has seen the patients. There are incentive bonuses for preventive care targets and for shadow billing for services and procedures that would have been covered under FFS (Canadian Medical Association, 2017).

Potential pros

- Positive impact on rural recruitment and retention
- Physicians receive a stable base salary calculated on the basis of number of patients rather than number of services
- This payment model can work well if physicians are provided with administrative supports to help establish, maintain and monitor their patient rosters
- Collaboration within health teams and the delivery of preventive care services and/or health promotion increases
- This model requires formally enrolling patients in a practice; this is associated with improved continuity of care, patient satisfaction and chronic disease management
- Physician incomes are higher in areas where this payment model has been introduced

Potential cons

- The success of this payment model is contingent on administrative supports to help establish, maintain and monitor a physician's patient roster. Efforts should be made to ensure physicians are not overburdened with administrative costs, increased overhead costs and unmanageable paperwork
- Patients with better health status may be selected, denying care to those who need it most
- Negation may be required to avoid shifting responsibility of care to other settings (physicians will lose payments if a patient seeks care elsewhere) or providers, but must be carefully considered and implemented
- Hospital/emergency room use may not decrease, despite incentives
- Responsibility for patient behaviour is shifted to physicians (The College of Family Physicians of Canada, 2016)

Doctors Nova Scotia is in the process of developing a new blended payment model that incorporates the best features of FFS and capitation payments in a comprehensive payment structure that supports better patient care, fair compensation for physicians and good stewardship of public funds. While FFS and APP payment models will still be preferable in some communities and practice structures, a blended payment model will be superior in others.

Payment Models and Collaborative Care

Wranik, Korchagina, Edwards, Levy & Katz (2015, p. 23) discuss how physician compensation models can affect team integration and counteract professional hierarchies in clinical decision-making:

- *The physician as the clinic model does not support team integration. Financially, the model centres on the activities of the physician. All other team members work to support the activities of the physician, who is the clinical decision maker. The contractual arrangement, where other health-care providers are employees of the physician, further cements the hierarchy, where the physician is the dominant team member.*
- *The physician as separate from the clinic model has a neutral effect on collaboration. The physician takes a special role within the clinic and has no incentive to collaborate with others. Their income depends on their own activities; in fact, if the physician receives the fee-for-service payment, their income is proportionate to the level of activity. Delegation of activities to other health professionals occurs, when activities are not remunerated or have a relatively low billable fee. Delegation and collaboration do not occur on the basis of patient needs or the identification of best provider for each task. In this model, the physician remains a clinical decision maker with no financial or contractual incentive to share decision making.*
- *The physician integrated into the clinic model counteracts a professional hierarchy by creating a uniform set of incentives for all team members. Neither the physician nor any other health professional is singled out as different from the rest of the team (by compensation method). In addition, the incomes of all health professionals are tied to the clinic's budget, thereby creating pressure for everyone to sustain the budget. If the budget is based on a patient roster capitation system, then it is in everyone's interest to maintain high patient volumes. A block allocation (based on, for example, a geographical catchment area capitation) removes the motivation to contribute to patient volumes.*

WORDS OF WISDOM

Dr. Holly Zwicker

Crossroads Family Practice

The funding model to keep a nurse working with you in collaborative care is not a great model for working with a number of different physicians if you are in FFS. The nurse has to see enough patients to generate revenue that covers both the overhead and her salary; there isn't much left to compensate physicians for the extra work they do in supervising a nurse and being responsible for all those patients that she sees.

If it is a service under FFS or one we intend to shadow bill, we have to also lay eyes on the patient. The way that the fee structure is set up, we have to follow the same rules for shadow billing under an APP; there are limitations on being able to use it in the full scope of practice.

Although our nurse is perfectly qualified to speak with a patient about an issue such as cardiovascular health, we cannot bill her time for lifestyle counselling; we have to do the lifestyle counselling as physicians.

- *The physician equivalent to other health professionals model also counteracts the professional hierarchy and medical dominance culture. A difference between this and the previous model is that this model offers more stability in income. The salary rate is not dependent on the clinic's budget. The absence of pressure to sustain the clinic's budget is not necessarily positive, in that the incentive for patient volumes is removed entirely. The Canadian Forces Primary Care Clinic, as an example, uses this model. A concern that was voiced during an interview is that patient volumes tend to be low and wait lists for primary care visits are higher than might be desirable.*

Researchers have identified several characteristics of effective funding and remuneration approaches for supporting collaborative care teams (Wranik et al., 2012; College and Association of Registered Nurses of Alberta, 2011). These include:

- Funding is linked to the activities of the whole team rather than to the activities of specific providers (that is, the physician)
- Patients are linked to teams rather than to individual providers
- Funding is calculated per patient rather than per service
- Funding is based on the needs and risk factors of the population served
- Funding clearly outlines and recognizes funding for members of interdisciplinary teams
- Funding is patient centered rather than provider driven, and provide incentives for comprehensive care
- Funding allows for adequate physical space to enable all team members to be integrated into the practice space
- Funding is dedicated to team development and supportive of collaborative practice

QUESTIONS *for Reflection*

When thinking about payment models, it may be helpful to consider these questions:

1. Which payment model best suits my philosophy of collaborative practice?
2. How much autonomy do I want in my practice?
3. How will the other providers in my practice be compensated?
4. Who is responsible for administrative duties in the practice, and how will they be compensated?
5. What are the overhead costs for my collaborative practice, and which payment model will best address them?
6. What are the needs of the local community?

Annapolis Collaborative Practice

Annapolis Royal

"Working in a collaborative practice provides the opportunity for sharing experiences, knowledge and workload equitably and efficiently."

When it comes to deciding whether or not to join a collaborative practice, Dr. Simon Bonnington, a family physician at Annapolis Collaborative Practice (ACP) in the Annapolis Community Health Centre (ACHC), has a simple piece of advice.

"Decide if you want to work together. If you do, do so," he said. "If you don't, don't try to force it."

The Annapolis Collaborative Practice (ACP) was formed in 2004. The team's composition has changed over the years – today the team includes Drs. Bonnington, Roop Conyers, Caroline Hancock, Jenna Hayden and Colin Newman; two resident physicians, Drs. Dannika Bakker and Hillary Lavelle; a family practice nurse (FPN), Beth Bent; and nurse practitioner

(NP) Erica Maynard. They're part of a broader collaborative grouping that includes another local family physician, Dr. Ken Buchholz.

When the ACP took over the southern wing of the ACHC for their office, they gave considerable input into redesigning the space. Exam rooms are clustered around a common printer and photocopier, and the staff share a staff room and communal office – which means the clinicians cross paths throughout the day. Physicians and patients also benefit from the clinic's location at the ACHC, which offers a broad array of diagnostic and support services.

"Working in a collaborative practice provides the opportunity for collegiate working – sharing experiences, knowledge and workload equitably and efficiently," said Dr. Bonnington.

"We each have our own areas of interest, which makes us a team with a wide range of clinical expertise," said Dr. Hayden. "Our collaborative environment means it's easy to get a colleague's opinion on a particular patient presentation or management. Working collaboratively doesn't just benefit our patients – it helps us become better physicians, too."

The team meets each morning; inter-professional rounds offer the physicians the opportunity to gather and discuss patient needs and to offer each other professional support.

Of course, being part of a successful collaborative practice requires more than daily morning meetings.

"Ensuring the perception of equity with workload and work-environment pressures is very important," said Dr. Bonnington. The practice has a Collaborative Emergency Centre (CEC) payment structure, which means they know in advance what their annual, and thus bi-weekly, incomes will be. It also lets the physicians determine the number of hours they will work per year, including weekday clinic shifts and on-call responsibility for inpatients.

"Having a good-size team is helpful," said Dr. Hayden. "It keeps our schedules manageable, and means that we're able to cover for each other during planned or unexpected absences. Working as a team helps provide a better work-life balance."

Outside of managing medical matters, each physician takes responsibility for a different aspect of practice governance, such as supervising medical learners, maintaining the EMR and managing finances. The physicians are all self-employed as individual signatories to their CEC contract, whereas the NP, FPN, and practice reception and support team are directly employed by the Nova Scotia Health Authority (NSHA).

Each physician pays a monthly sum to NSHA to cover their share of the salary costs of the reception team and other overhead costs, such as office space rental and maintenance. IT costs and telecommunications are shared out separately. The NSHA contributes an equal share toward those costs on behalf of the NP and FPN.

Keeping it all running smoothly requires constant communication and open minds.

"We schedule regular face-to-face group meetings," said Dr. Bonnington. While patient care decisions are made by the clinicians, the whole team (including office support staff) has input into work-flow decisions.

"It's important to play to each other's strengths," said Dr. Newman. "We make decisions by committee and always strive to reach a consensus."

"We try to make things work," said Dr. Bonnington. "Our response to requests is 'Yes, if….' We identify the conditions and supports needed for something to be successful and try to move it forward."

Structural Considerations

THIS SECTION'S
Key Concepts

- Physical space as a structural factor
- Overhead and how it affects a practice
- Important information technology (IT) tools for collaborative practices

Physical Space

The arrangement of the physical space, including offices, exam rooms, administrative and record keeping spaces, as well as potential allied health-care providers/services, is an important consideration for a collaborative practice; it can support inter-professional collaboration (Goldman et al., 2010) and improve clinical outcomes (Canadian Nurses Association, n.d.).

Spaces designed and organized for collaboration do not reflect the traditional hierarchy of positions so common in primary health care, but instead eliminate barriers to effective communication among all members of the team (WHO, 2010). Well-designed team stations or pods can improve efficiency and strengthen culture in a medical practice (American Medical Association, 2017; Nova Scotia DHW, 2016).

Some suggestions for organizing space to promote collaboration, encourage care teams to work more closely and gel as teams, help teams function more effectively and efficiently, and potentially improve patient outcomes and lower health care costs, include:

- Placing examination rooms close to the team's work area – this minimizes the space that must be travelled between tasks, and improves visibility to exam rooms
- Having team stations within visual and physical proximity to examination rooms – this helps the team develop situational awareness that helps them manage patient flow throughout the day
- Having clustered spaces for health-care providers – this facilitates opportunities for informal meet-

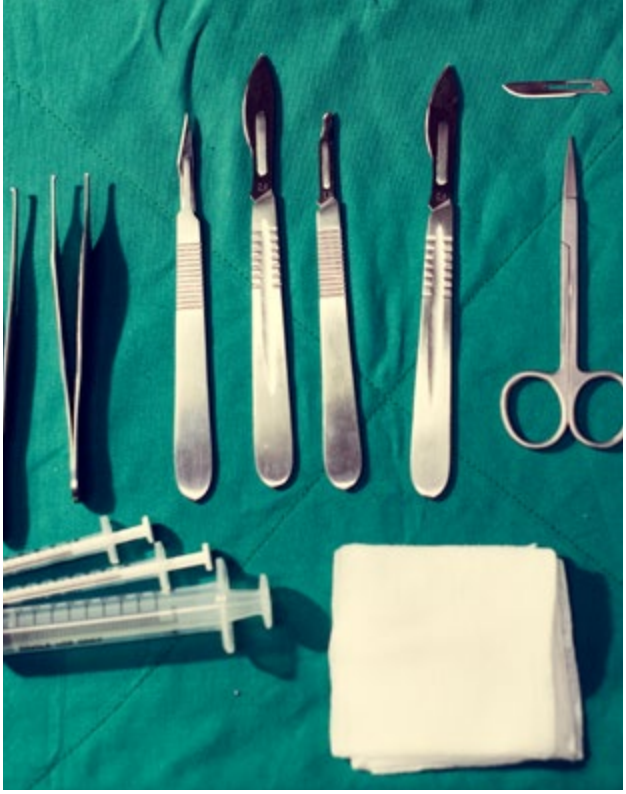
ings, collaboration and educational sessions
- Integrating spaces for learners, visiting specialists and community-based services and programs
- Creating a space that is quiet and yet still supports communication, and protects and preserves privacy and confidentiality

While the actual physical design of the space is an important consideration for facilitating collaboration, the process of designing and creating the space also has a significant impact on how team members and the public feel about the space.

Every community has different characteristics, strengths, needs and ways of doing things. Engaging physicians, allied health providers and community members in creating the space facilitates a sense of buy-in and ownership of the practice and will ultimately contribute to the satisfaction of the physicians and the sustainability of the practice.

Implications of Physical Design for Collaborative Practice

- Quantity and quality of collaboration of interprofessional teams are strongly associated with shared space and time. These help build team relationships and trust, and establish roles and responsibilities
- Informal, nonclinical design may lead to greater cohesion and connectedness of the team, regardless of their professions
- Time pressures and constraints resulting from patient care schedules make meaningful communication between team members extremely difficult. The most common form of communication between team members is informal, unstructured and unplanned
- A lack of shared space and time can aggravate professional silos and the sense of exclusion from the core team. There must be formal and informal communication. Both are central to relationships, patient-centred care and effective collaboration. Scheduling also aids the process as do certain evidence-based communication tools
- A lack of shared physical spaces that are conducive to communication and collaboration can contribute to a lack of knowledge about the other professionals' roles (Conference Board of Canada, 2012)



Overhead

Overhead costs associated with running a medical practice typically include the following:

- Professional expenses, such as medical association dues, licensure dues, Canadian Medical Protective Association fees and practice overhead insurance
- Operating expenses, such as offices expenses, ongoing IT costs, rent, utilities, staff salaries and insurance
- Capital expenses, such as office equipment, furniture, IT, EMR, and office renovations or leasehold improvements (Canadian Medical Association, 2017)

Cost-sharing is identified as an important benefit of collaborative practice. Depending on the practice's physician remuneration model and governance model, a range of costs can be shared among physicians.

A contract can help clarify the expectations of each partner in the cost-sharing agreement. It should explain:

- The purpose of the clinic, and services offered
- The nature of the relationship between physicians, as well as their responsibilities and their responsibilities for patients
- How the clinic will be managed
- Who can make decisions
- Accounting and bookkeeping practices
- Anticipated expenses

WORDS OF WISDOM

Dr. Simon Bonnington

Annapolis Collaborative Practice

One of the significant factors in making our collaborative practice work is that we use an EMR.

WORDS OF WISDOM

Dr. Holly Zwicker

Crossroads Family Practice

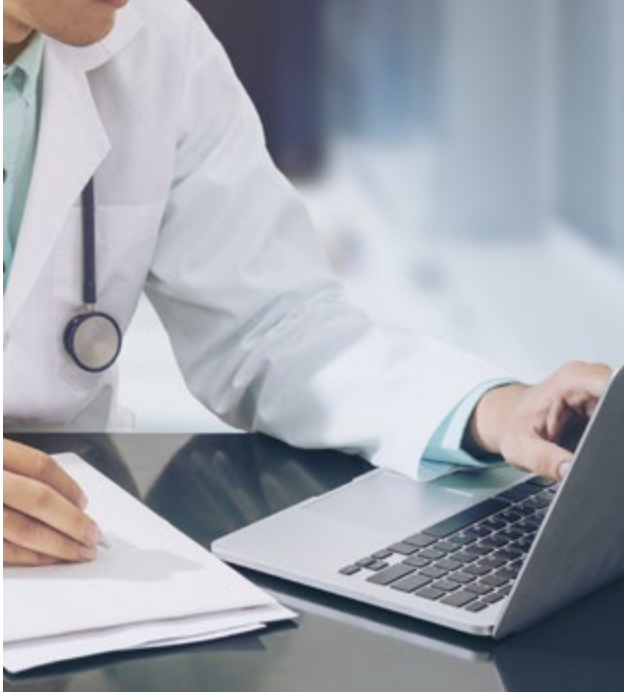
Part of the drive for us to set up with an EMR was to build it to be what we want, and use it as a tool for better care, for both preventative care, chronic disease management and wellness. We want to make things easier, better and more streamlined and efficient in health care. We use our EMR to its full potential.

- How costs will be allocated (e.g., a fixed amount or a percentage of costs incurred)
- Hiring of staff
- Physician vacations and leave
- Whether new members to the agreement are permitted
- Details regarding termination of the agreement (Doctors Nova Scotia, n.d.)

Potential Implications of Cost-Sharing Agreements

- Capital and ongoing expenses can be shared in group practices
- Depending on the payment and/or governance model of the practice, expenses could include salaries of some team members (such as nurse practitioners, family practice nurses and administrative support staff)
- Renting reduces maintenance and repair costs; owning a space requires planning to cover these costs in the long term
- The process of working through a cost-sharing practice contract can be helpful for defining parameters for collaboration
- Sharing costs of support staff and allied health-care providers means sharing and coordinating their time and skills
- Cost-sharing arrangements need to be negotiated and documented carefully

If establishing a collaborative family practice team that receives funding from the NSHA, a Memorandum of Agreement (MOA) is required. Depending on the team's governance model, the MOA will describe the roles and responsibilities of the parties as well as the funding for the team. In the case of a contracted services or co-leadership governance model, the NSHA will contribute overhead funding for the team members; in the case of a turn-key governance model, the physicians would contribute overhead to the NSHA for associated costs.



Information Technology

Technology is important in a system that emphasizes collaboration between health professionals because it can improve communication and coordination between services, systems and specialists. Electronic communication and technology help team members avoid duplication, choose treatments wisely and ensure improved access to care. This section describes two important tools for collaborative practices: the electronic medical record (EMR) and the personal health record (PHR).

ELECTRONIC MEDICAL RECORDS

The use of EMRs has been shown to improve communication and enhance interaction between team members and between service providers and their patients (PWC, 2013).

Doctors Nova Scotia lists the following potential benefits of EMRs for primary health care:

Improve patient health outcomes

- Deliver chronic disease management and care of complex patients
- Maintain more complete, consistent and legible records for efficient, logical and reliable access (best accomplished if all providers chart similarly)
- Access lab results and current medications quickly and easily
- Graph lab results, medications and trends
- Generate decision support and reminders for physicians and staff
- Aggregate reports to better understand patient population

Strengthen patient safety

- Minimize risk of missing/forgetting important details
- Check for drug interactions or contraindications
- Monitor medication lists and current prescriptions

Enhance revenue/increase productivity

- Simplify and optimize billing with correct codes
- Reduce manual labour with automated filing and form-filling
- Generate end-of-day reports
- Save time with computerized record searches
- Add lab and imaging results to patient's record
- Integrate diagnostic devices and input results and findings into patient's record
- Free up office space no longer needed to store paper charts
- Free up the time of office staff, which allows practices to encourage interaction with patients

Enable a flexible work environment

- Access charts from anywhere at any time
- Streamline interoffice communications

Improve personal information privacy/security

- Allow only authorized users secure log on
- Track and audit user access with automated logs and processes

Provide better legibility and continuity

- Avoid mistakes caused by illegible handwriting
- Help colleagues access patient information while covering vacations and absences
- Attract locums or partners to an organized, modern practice

The CFPC recommends that by 2022 all family physicians should be using EMRs in their practices, noting that the more consistently physicians utilize EMRs, the more complete and effective the data in the EMRs will be. As of 2017, 82.4% of Canadian family physicians were using EMRs to enter and retrieve clinical patient notes (CMA Physician Workforce Survey, 2017). The study estimated that Nova Scotia's EMR adoption rate is 78% for family physicians.

There are currently four EMRs in use in Nova Scotia: Telus Health-Nightingale, Telus Health-Practimax, Telus Health-Med Access and QHR Technologies'

Accuro EMR. Only two of these products (Telus Health-Med Access and QHR Technologies' Accuro EMR) are undergoing provincial certification, therefore new physicians entering practice in the province should choose between these two solutions.

The Telus Health-Nightingale system will be discontinued in December 2019. Physicians using that product must migrate to one of the two certified products. Incentives are in place to support this migration – information is available through DNS. Telus Health-Practimax users should contact Telus Health for information on their options going forward.

A $10,00 incentive payment is available for physicians who will implement an EMR for the first time during the last year of the current Master Agreement contract (April 1, 2018, to March 31, 2019). Physicians are also eligible for an annual participation grant ($2,000) and a variable utilization grant. Contact DNS for details on these payment incentives.

USING AN EMR IN A COLLABORATIVE PRACTICE

The CFPC (2016) offers the following tips for adopting EMRs in the Patient Medical Home:

- **Define practice needs:** Consider how day-to-day clinic activities are managed, inclulde factors such as team composition and location, to help define needs.
- **Select an EMR:** Spend time researching and communicating with vendors, to fully understand what is included before making the purchase. [Physicians in Nova Scotia can also consult with one of DNS's EMR advisors.]
- **Determine resource requirements:** When establishing a budget, consider costs that might be incurred during project implementation, as well as costs for supporting the ongoing operation of the EMR system.
- **Transfer from paper charts:** Paper records can be scanned into the system as images or can be entered manually into the EMR. Transfer of personal patient information contained within the records must remain secure at all times.
- **Learn how to use an EMR:** There are many courses available from a variety of sources, including EMR vendors, hospitals and universities, which can help further the physician's and team's knowledge of tools to use within the EMR system in their practice. These courses are offered in different formats, including live events and online modules.

Considerations for Using an EMR in a Collaborative Practice

- Use of an EMR has been shown to positively impact team climate among family health teams (Howard et al., 2011)
- Cost-sharing or financial sponsorship from government entities is required to support the high cost of EMR adoption (CFPC, 2011)
- Effective use of an EMR can comprehensively capture the various services that qualify for bonuses offered through an APP, and ensure that accurate records of all clinical and non-clinical services provided are documented and made eligible for APP benefits
- Primary care clinics can have a positive return on their investments in Electronic Medical Records within three years. Money is saved through reducing or eliminating chart pulls; reducing time to sort, archive and retrieve laboratory and diagnostic test reports; and enhancing patient scheduling and billing practices (PWC, 2013)
- Using an EMR helps a practice meet accountability standards through effective and comprehensive documentation (Canadian Medical Association, 2012)
- Collaborative practices in particular may benefit when the additional administrative and communication tasks associated with collaboration are effectively documented through the use of an EMR
- McLaren (2010) advises a careful "workflow assessment" in order to determine choice of EMR

system and features. The decision to adopt an EMR does have significant financial implications, including start-up costs, ongoing maintenance and system upgrades, and changes in productivity during and after the transition
- There are limitations to electronic communications, and protocols need to be developed to ensure security and effectiveness of use

PERSONAL HEALTH RECORDS

Non-face-to-face communication with patients has many benefits and has been associated with improved effectiveness and timeliness of care. Online portals that allow patients to access and update their own medical records can:

- Allows patients to track their own health trends, goals and results
- Increase patient engagement and satisfaction
- Improve the accuracy of records
- Improve the timeliness of receiving test results
- Potentially prevent the need for an in-person office visit (Canada Health Infoway, n.d.)

Nova Scotia's Personal Health Record solution is called MyHealthNS. MyHealthNS provides Nova Scotians with the opportunity to communicate with health-care professionals over the Internet. This secure online portal can be reached through any device with Internet access – it provides patients and health-care professionals with up-to-date information, enables access to test results, and provides the option to send and receive messages. Patients are encouraged to upload their personal health data into the system. MyHealthNS enables the patient to become a valuable partner in their own health care.

In August 2018, the Nova Scotia government announced a Virtual Care Technology Incentive Stipend for MyHealthNS and Use of Telephone for family doctors across the province. Family physicians who use MyHealthNS and the telephone to provide non-face-to-face care and share test results with their patients electronically may receive up to $12,000 over a 12-month period. In order to participate, physicians must agree to:

- Enrol their patients in MyHealthNS (sending at least 20 e-invitations to patients per month)
- Release e-results to their patients (either automatically or with a delay)
- Respond to e-Messages from patients with a target of a two-day response time
- Assist in feedback to inform the 12-month pilot analysis

The stipend is now available and is intended to bridge to the next Master Agreement. If you are interested in learning more about the program, please express your interest in an email to MyHealthNS@novascotia.ca or contact your DNS Physician Advisor.

WORDS OF WISDOM

Dr. Greg Thibodeau

South Shore Network

Physician Lead

Given the prevalence of chronic diseases and the current health-care climate, we must engage in dialogue and examine the appropriate roles our allied care colleagues may play: traditional Chinese medicine, acupuncture, osteopathic manipulation, chiropractic medicine and natural medicine in particular. Such considerations make for a more comprehensive collaborative model moving forward in our goals of health and wellness.

QUESTIONS *for Reflection*

When thinking about how the structural considerations of your collaborative practice, consider these questions:

1. What space and layout would support the type of services and activities taking place at the practice?
2. How can practice stakeholders be engaged in considering the space needs?
3. What are all the costs associated with running my practice? How will the physicians/allied health providers share these costs? Could any of the costs be covered by the NSHA? Could any of the costs be covered by another organization, such as the municipality, community businesses or a foundation?
4. Which EMR would meet the practice's needs? How will the EMR be funded?
5. What training and supports are required? Who are the experienced users who can share insights about each system?
6. How should we leverage technology for a more efficient, better patient experience? Should the practice utilize MyHealthNS?

Clare Health Centre

Meteghan Centre, N.S.

"If you feel it's important, take responsibility and make it happen – don't wait for someone else to make it happen."

That's a sentiment that you'll hear again and again in Clare, a francophone community on Nova Scotia's southwest shore. Fifteen years after municipal voters first identified a health centre as the area's highest priority – even though health care isn't a municipal responsibility – the area's comprehensive health centre is the pride of the community.

Numerous physicians, politicians and community members started the movement, and after several years of hard work they were able to design, fund and staff the Clare Health Centre, now a collaborative care clinic. Drs. Alain Blinn, Erica Lasher Coates, Michelle Dow, Giselle Dugas and Jean-Luc Dugas provide primary health care for residents of the Municipalité de Clare, working with an NP and an FPN (starting

in January 2019), as well as office staff and patient attendants. Visiting health-care providers provide diabetic care, nutritional advice and cardiovascular care on a regular basis, and the area's Continuing Care, Public Health, Addiction Services and Mental Health services are located in the building's lower level, making it easy for physicians to consult about patient needs.

The municipality owns the building, employs the clinic manager, front office staff and patient attendants, and rents office space to the members of the collaborative practice as well as the other health service providers. The physicians are paid by the Department of Health and Wellness through MSI (one on an FFS contract, with the remaining physicians on APP contracts) and pay rent to the municipality from their earnings. The NP and FPN are paid by the Nova Scotia Health Authority (NSHA), which also pays for the NP's office rent. The NSHA also pays rent for the allied health services located onsite.

It's a true community clinic, said Municipal Warden Ronnie LeBlanc. "The community is 100% behind the health centre – they call it 'our health centre,'" he said. The $4 million needed to build the clinic was provided by the municipality, as well as by community fundraising efforts, which included a golf tournament that has become an annual affair.

And the community involvement doesn't stop there.

"All the doctors are from the community," said medical director Dr. Michelle Dow. "We share the same culture and language, and we all know each other and care about each other."

Recruitment starts early, with physicians visiting the local high school to encourage students to consider medicine as a career option. Students who do go on to attend medical school receive congratulations and care packages from the municipality during the school year, and are treated to dinner at Christmas on an annual basis with the members of the Clare Doctor Recruitment Committee.

"The medical centre is a good recruiting tool," said Dr. Dow. The financial support that the municipality offers to returning students doesn't hurt, either. And collaborative practice offers myriad opportunities for mentorship.

"I was very interested by the fact that I would be practising in a group setting, with other new physicians who had taken the same academic path, as

well as some more experienced ones with different backgrounds," said Dr. Courtney Mazeroll, a former staff physician at the Clare Health Centre. "I knew that if I had any questions or needed help that it was only a short walk down the hall to find it."

"In a collaborative practice, we don't have to be everything to everybody," said Dr. Dow. "Everybody has niche things they like to do, so we have opportunities to tailor our work to our interests and skills, whether that's providing care in nursing homes or student health clinics, doing vasectomies or doing emergency coverage."

Collaborative practice works in Clare, enabling the physicians in the practice "to work with our partners in the community to enhance care and access for our patients and residents in the area," said Dr. Dow.

Providing Care as a Collaborative Team

THIS SECTION'S
Key Concepts

- What it means to provide care as a collaborative team
- Potential benefits and challenges of the collaborative approach to primary care
- Possible iterations of a collaborative care team; issues to consider in building such a team; and various approaches to team leadership

Definition of Team-based Care

Providing care as a collaborative team can include:

- Organizing and working as a team, while effectively utilizing the separate and shared knowledge, skills and interests of patients, providers and office staff
- Identifying, exploring, managing and/or solving patient and population health concerns, with the best possible participation of the patients, families and communities, to improve health outcomes and use of resources
- Recognizing, utilizing and respecting the strengths and integrity of each team member's approach and contribution to care in collaboration with the patient, developing and utilizing a shared plan of care
- Establishing consistent approaches to care in collaboration with the patient so that the individual patient's values and experience of care is consistent across the team
- Practising in a way that optimizes the scopes of practice of all team members, including office staff, and creates efficiencies in administering and delivering primary health-care services

WORDS OF WISDOM

Dr. Caroline Hancock

Annapolis Collaborative Practice

Our long-term "morning rounds," which initially focused on inpatient review and ER handover, gradually expanded, moved to a larger room, and included a larger number of health professionals, which added to the coordination of care our patients received, and also gave us a daily opportunity for fruitful interdisciplinary discussion.

Potential Benefits of Team-based Care

The CFPC (2017) outlined key benefits of team-based care:

- Expanded access to care: Collaborative teams can offer timely access to care (for example, by sharing responsibility for extended office hours and offering a broader range of services), which can reduce wait times, improve patient outcomes and increase patient satisfaction
- Efficient use of resources: Regular access to team-based care in a family practice reduces patients' use of emergency medical services and overuse of health-care services
- Continuity of care: A coordinated and connected team can effectively attend to patients' needs, reduce duplication of unnecessary testing and reduce omissions in care
- Improved chronic care management: Collaborative teams can play a vital role in mitigating risk factors and improving clinical outcomes for patients with chronic diseases by assisting with planning, counselling and follow-up services

Potential Barriers to Effective Team-based Care

The CFPC (2017) also identified potential barriers that must be addressed in order to offer effective team-based care:

- Funding models can be a significant barrier to interdisciplinary primary care practice – if the physician receives the funds for primary care services, there may be less incentive to share service provision or decision-making responsibilities with other team members. An APP or blended payment model (such as the one in development by DNS) may be more conducive to effective collaborative practice than a fee-for-service funding model.
- Lack of clarity can result in ambiguous expectations and confusion within the team about roles within a practice, resulting in suboptimal patient care.
- Not understanding each other's roles, responsibilities and accountabilities can negatively impact team effectiveness and collaboration, and may cause team members to perceive or project an artificial professional hierarchy. Although the family physician often assumes the greatest responsibility in medical decision-making, this is not always the case for other areas of care.
- Communication inefficiencies can affect the team dynamic and jeopardize patient care. Medical errors can occur if critical information is not passed on, information is misinterpreted, next steps are unclear or changes in a patient's status are overlooked.

ORGANIZATIONAL-LEVEL FACTORS THAT FACILITATE COLLABORATION

- Geographic proximity of partners and working arrangements that are conducive to collaboration
- Leadership that includes the use of community-based committees or boards with diverse membership to facilitate planning
- Involvement of variety of professionals
- Structures and processes that support team communication, autonomy, minimizing of competition, opportunities for all to function at their fullest scope of practice
- Contractual agreements, parallel reporting and common governance structures
- Use of standardized and shared system for collecting data and disseminating information, as well as linked electronic records to support effective interdisciplinary care
- Shared protocols for multi-disciplinary, evidence-based practice and quality assurance; and strategies and processes of care
- Dissemination of information and evidence-based tool kits and decision support tools
- Compensation models that support collaboration
- Organizational support for the team

(Compiled from Nicholson et al., 2013; Valaitis et al., 2012; Virani, 2012)

Composition of Collaborative Teams

There is no one-size-fits-all model when it comes to the composition of collaborative health care teams. There must be flexibility in the model of care delivery as well as in the composition of the collaborative team, in order to be a good fit for the community. Some of the factors that must be considered are:

- The characteristics of the community (demographics, geography, culture, language, health status)
- The skills and experiences needed to best address the health needs of the community
- Existing services
- Gaps in services
- The community's thoughts about health challenges and solutions for addressing them

Doctors Nova Scotia believes that family physicians are the cornerstone of collaborative care. Family physicians work closely with other health-care providers to deliver high-quality health care. The CFPC (2017) provides a list of potential collaborative team members and describes their respective areas of responsibility.

HEALTH-CARE PROFESSIONAL	SAMPLE AREAS OF RESPONSIBILITY
Registered nurses (RNs)	Health promotion, disease prevention and management, coordination, education, direct patient care, and health assessments for patients and families across the continuum of care
	Collaboration with and referrals to other community services
	Oversight and contributions to clinic/centre high-quality care
	Coordination of health promotion activities in the community
	Coordination of specialty clinics/education/research/administration/quality improvement
Nurse practitioners (NPs)	Registered nurse responsibilities as above
	Diagnose and treat illnesses
	Order and interpret tests
	Prescribe medications
	Perform medical procedures
	Admit and discharge patients
	Complete physical and mental health assessments
	Make specialist referrals
Dietitians	Counseling and supporting clients to change their eating habits to promote good health and prevent chronic illness
	Developing and implementing plans for individuals, groups and communities based on a comprehensive needs assessment; monitor progress, provide ongoing support and evaluating outcomes
	Applying knowledge of health determinants, and working with communities, groups and individual clients to plan and implement programs
Psychologists	Carrying out needs assessments of the practice's patient population
	Designing and evaluating evidence-based mental health programs to meet these needs
	Planning and supervising the delivery of mental health services by other members of the team
	Identifying and managing the psychological issues that may get in the way of patients making changes necessary to improve their health; may help patients adhere to medication or other treatment protocols and better manage chronic physical illness
	Helping a patient's family manage the demands and fatigue of care-giving

HEALTH-CARE PROFESSIONAL	SAMPLE AREAS OF RESPONSIBILITY
Social workers	Assessing social problems by obtaining case history and background information Contributing knowledge to the health team about family dynamics, family functioning and attitudes toward others, and interpersonal behaviour Providing information regarding patient and caregiver ability to interpret and understand the team's recommendations and care prescribed Providing individual, family, caregiver and group counselling Helping patients and caregivers navigate the health system, and access necessary services
Physician Assistants (PAs)	Conducting patient interviews, taking medical histories and performing physical examinations Diagnosing and treating illnesses Ordering and interpreting diagnostic tests Developing treatment plans and counselling about preventive health care
Other Health Care Professionals including (but not limited to):	
Physiotherapists	Manage acute and chronic conditions, activity limitations and participation restrictions. Help with the rehabilitation of injuries, and the effects of disease or disability with therapeutic exercise programs and other interventions
Occupational therapists (OTs)	Enable individuals, groups and communities to identify, engage in and achieve desired potential in the "occupations of life" Work with patients to plan how to prevent or overcome the barriers in their lives
Chiropractors	Assess, diagnose and manage musculoskeletal conditions using non-invasive, nonpharmacological manual therapies
Pharmacists	Provide optimal drug therapy outcomes in collaboration with patients, caregivers and other health-care providers Identify medication use issues Take responsibility for drug therapy decisions Monitor outcomes
Speech language pathologists	Identify, diagnose and treat communication and swallowing disorders
Audiologists	Identify, diagnose and manage individuals with communication disorders

WORDS OF WISDOM

Dr. Maria Patriquin

Living Well Integrative Health Center

A collaborative care model is only as healthy, functional and happy as the people who work and function within it. This speaks to the importance of physicians and health-care provider's health. This must consider their needs and the importance of their work/life balance as well as the need to be engaged in healthy practices themselves. Providers must be heavily encouraged to self-care, be mindful and responsive to their changing needs, to establish a sense of safety, security and stability as well to ensure that they are deriving from their work role a sense of meaning, purpose and mastery. Providers need care and need to take care.

WORDS OF WISDOM

Dr. Greg Thibodeau

South Shore Network Physician Lead

It is from here that a health home is built: we work from the strengths of the team members, with allocated time for sub-specialties; this maximizes strengths. There is no longer an "I" in medicine. We work best in teams, but it has to be the right fit. If a person doesn't fit in the practice, it is not going to work – MDs or NPs. Empower doctors to choose their team members.

Considerations for Collaborative Practice

- Team-based care that is implemented well has the potential to improve the comprehensiveness, coordination and efficiency of a practice. To achieve this potential, practices transitioning to a team-based care model need to ensure that they are ready to accommodate any changes to the practice culture, the nature of interactions among colleagues and patients, and education and training (The College of Family Physicians of Canada, 2017).
- During the planning and team development phases, roles should be clearly outlined. This is best done at the local practice level relative to community needs and resources. This approach considers changes over the course of a health care professional's career, including skills development, achievement of certifications and professional interests. It is important to include time for team members to become comfortable in their role, at the outset of team-based care and with any changes to the team (The College of Family Physicians of Canada, 2017).
- Developing and implementing a standard set of behaviour policies and procedures can create clear expectations between different members. Ensure the policies are consistent, universally applied and do not show favouritism to specific roles. Encouraging informal or formal group interactions can also help enhance collaboration between perceived hierarchical roles and break down any silos that may exist (The College of Family Physicians of Canada, 2017).
- Effective communication is essential for ensuring that care is continuous and patient-centered, as well as coordinated and coherent (The College of Family Physicians of Canada, 2017).
- Depending on the model of the collaborative practice, some team members may be employed by and selected by the NSHA.
- Although leadership may be shared and adaptive among team members and a physician may not necessarily be leading the team at any given moment, they ultimately bear full responsibility for the patient's care (Alberta College of Family Physicians, 2011).
- The family physician guides the tone, goals and culture of the team by coordinating care, collaborating with other health care professionals and building and strengthening working relationships (Alberta College of Family Physicians, 2011).
- Appropriate payment models (such as APPs and blended payment models) must be available to support the delivery of optimal comprehensive and collaborative care.

INTERACTION-LEVEL FACTORS THAT FACILITATE COLLABORATION

- Clear roles and responsibilities for all partners, and a good understanding of one another's roles and scope of practice
- Shared vision, purpose, philosophy and identity, such as shared commitment to quality care, patient safety and working as partners
- Developing and maintaining good relationships, including mutual trust, tolerance and respect, commitment to building relationships, willingness to cooperate and collaborate
- Effective communication, including regular staff meetings, involvement of the whole team, consensus building, joint planning, listening to community partners
- Clear strategies for decision-making

(Compiled from Nicholson et al., 2013; Valaitis et al., 2012; Virani, 2012)

GROUP MEDICAL VISITS

Dr. Maria Patriquin, of Living Well Integrative Health Center, offers group medical visits in her practice.

Group medical visits allow patients to access care, education and advice in a group of eight to twelve people, typically with a common medical condition. Sessions last 60 to 90 minutes and can involve a doctor or nurse practitioner and other health professionals. Each session includes a medical component specific to the condition, for example a blood pressure check and a review of lab results. The second component is educational and focuses on health promotion. As such, the second component is often geared toward lifestyle interventions.

Leadership

Identifying strong leadership for collaborative practice is essential. Effective leaders in the health-care system could be physicians or others with delegated authority as team leaders and should demonstrate a good understanding of:

- Government functioning
- Health-care system challenges, policies, legal issues and the dynamics of health-system change
- Management issues such as accounting, finances and personnel management
- Health care improvement models and principles
- How to define and measure health care service performance and quality improvement

Personal traits and abilities of effective leaders in the health-care system include:

- Emotional intelligence, charisma and intellectual curiosity
- Passion for ongoing learning
- The ability to generate new ideas and to articulate a clear vision for the future that balances individual self-interest and the larger purpose of the organization
- The ability to work closely and cooperatively with others, to delegate and to engage in collaborative problem solving
- Effective communication skills and the ability to persuade and facilitate participation of others
- Commitment to high personal ethical standards
- Commitment to the ideals of medicine through traits such as compassion, hopefulness, caring and empathy

(Denis et al., 2013, p. 27-28)

LEADERSHIP PRINCIPLES THAT SUPPORT COLLABORATIVE PRACTICE

- Work with others to enable effective patient/client outcomes
- Advancement of interdependent working relationships among all participants
- Facilitation of effective team processes
- Facilitation effective decision-making
- Establishment of a climate for collaborative practice among all participants
- Co-creation of a climate for shared leadership and collaborative practice
- Application of collaborative decision-making principles
- Integration of the principles of continuous quality improvement to work processes and outcomes

(Canadian Interprofessional Health Collaborative, 2010)

WORDS OF WISDOM

Dr. Michelle Dow

Clare Medical Centre

I love the collegiality between colleagues, being able to bounce ideas off one another, being able to talk about an interesting case and being able to support one another in stressful times. I really believe in mentoring young doctors. I love knowing that critical lab values will be seen and acted upon by someone if I am away. I love going to a place of work where I am supported by my colleagues, where we respect and trust each other.

Leaderful Practice

Leadership as a collective property is sometimes called leaderful practice and is based on four critical tenets:

- Collective leadership means that everyone in the group can serve as a leader; the team isn't dependent on one individual to take over.
- Concurrent leadership means that not only can many members serve as leaders, but also that they can do it at the same time. No one, not even a supervisor, has to stand down when any team member is making his or her contribution as a leader.
- Collaborative leadership means that everyone is in control of and can speak for the entire team. All members pitch in to accomplish the work of the team. Together, they engage in a mutual dialogue to determine what needs to be done and how to do it.
- Compassionate leadership means that team members commit to preserving the dignity of every individual on the team, considering each when a decision is made or action taken.

Leaderful team designs are thought to produce effective outcomes because they engage everyone in mutual action. Everyone's talent is allowed to shine through and contribute to team goals. People can bring their whole selves to work and feel at home contributing to the greater good (Raelin, 2004).

QUESTIONS *for Reflection*

When thinking about providing care as part of a collaborative team, consider these questions:

1. How many patients will the practice serve, and what are their health needs and challenges?
2. How many hours are needed for patient access? How many hours will be available for each physician to work? How can schedules be arranged to extend office hours without burdening physicians?
3. How many non-physician providers are available, and what are their roles? How will they be paid?
4. What funds are available to support the practice?
5. What kind of payment arrangement or team structure/flow would allow family practice nurses and nurse practitioners to work to their full scopes of practice?
6. How can patients be engaged in setting the practice's vision and care-delivery model? For example, could they share input/feedback about programs/services, about potential additional service providers, about methods for sharing health information, or about care delivery?
7. How does sharing the goal of providing each patient with the most comprehensive care possible help team members work independently and while appreciating the unique contributions each brings to the team?
8. What practices (such as education/rounds, regular staff meetings or huddles, using technology and co-locating team members) can the team establish to create a community that is encouraging, trusting, transparent and respectful?
9. What type of communication will work best for this unique team, without creating a burden on team members?
10. How can technology assist between team members and with patients?
11. How will you know if the team is working effectively? For example: by services provided to patients, by patient outcomes, by team members' job satisfaction, by the quality of relationships among team members, by achieving shared objectives, and/or by efficiency and financial performance?
12. What is the leadership model for the practice? How will that affect patient care? How will it affect the collaborative team?
13. How will time used for leadership responsibilities be compensated?

Liability Issues

THIS SECTION'S
Key Concepts

- Liability risks within a collaborative practice
- Strategies for enhancing patient safety
- Strategies for mitigating risk

WORDS OF WISDOM

Dr. Maria Alexiadis

Family physician

Clearly articulated roles and responsibilities for all team members can help ensure that everyone is working to their scope of practice, maximize the contributions of each team member and minimize risk.

Clear, consistent, regular, honest and respectful communication means the right person is making the appropriate decisions about care, and we have a shared understanding about who is providing what supports.

Professional Liability

The McGraw-Hill Concise Dictionary of Modern Medicine defines "professional liability" as:

> *The obligation that a professional practitioner has to provide care or service that meets the standard of practice for his/her profession, i.e., responsibility; when a professional fails to provide the standard of practice, liability refers to the obligation to pay for damages incurred by negligent acts.*

The Canadian Medical Protective Agency (CMPA) acknowledges that well-functioning teams have the potential to deliver superior health care and, conversely, poorly functioning teams can increase risks for patients. It recommends the following steps for ensuring that policies and procedures defining and describing team functions establish a rigorous accountability regime:

- Provincial/territorial health professional regulatory authorities for each health profession should mandate that scopes of practice be updated in light of evolving collaborative care practices
- Working together, regulatory bodies must ensure gaps between scopes of practice are minimized
- Operating within the scopes of practices established by regulatory bodies, collaborative care teams must formally establish their own accountability arrangements

The following key practices are recommended for health professionals who work collaboratively:

- Health-care professionals must act according to the standards/scope of practice of their professions and comply with their respective regulatory colleges
- Establish policies to guide interdisciplinary care, specifically to clarify roles and responsibilities and processes related to communication, decision-making and patient management within the team approach
- Ensure that the organization has malpractice liability insurance that covers the organization and its employees (including direct liability and vicarious liability)
- Ensure that all professionals have appropriate malpractice liability insurance/protection. Institutions should reinforce this during annual performance reviews or appraisals (Prada et al., 2007, p.iii)

Liabilty Implications for Collaborative Practice

The CMPA describes several liability implications for collaborative practices:

- It is essential for collaborative care teams to have a policy and procedures framework with clear and agreed-on responsibilities and accountabilities – this promotes patient safety, reduces the risk of medico-legal issues and provides a documented record that may be needed if a problem arises.
- Collaborative teams need to clearly articulate responsibilities for coordination of care and team leadership. One perspective is that a single professional (usually the physician) ultimately needs to be responsible for all clinical decisions and actions. Another perspective is that the team practices as a collection of professionals within their own professional scopes of practice, co-provides care and collectively shares responsibility for outcomes. A third perspective is that the health professional, permitted by their regulatory authority to independently provide care, assumes responsibility – and therefore accountability – for those health decisions arrived at independently. This discussion raises important issues pertaining to direction of care, the delegation and supervision of medical acts, accountability and liability and patients' understanding of the team's approach to care.
- Health professionals should clearly understand the scopes of practice of those with whom they work. Delineation of responsibilities should be well-documented, particularly where scopes of practice within a team overlap. (One source of this information is professional associations.)
- The overall responsibility for health care decisions should be clearly specified and understood by all. This underscores the importance of effective and efficient communications within the team, with the patient and across teams. Care should be clearly documented.
- Team members have a responsibility to each other to carry adequate medical liability protection. They should confirm that other team members have adequate liability protection. Professionals working in collaborative care may share responsibilities that were previously performed solely by

QUESTIONS *for Reflection*

The Canadian Medical Protective Association identifies a number of questions collaborative teams must be able to answer in order to reduce clinical risk for patients and reduce exposure to medico-legal risk for individual providers. These include:

1. Are the roles and responsibilities of each team member clearly defined, based on their scopes of practice and each individual's knowledge, skill and ability?
2. Does every team member know their role and the role of the other team members?
3. How will health care decisions be made? Who is responsible and therefore accountable for health-care delivery decisions?
4. Is there a quality assurance mechanism to monitor the team function and health outcomes? What are the anticipated health-care outcomes the team is striving to achieve?
5. Has the patient remained an integral, if not a central, member of the team?
6. How will the team manage patient expectations and respond to patient concerns?
7. Is there a sound policy and procedural framework in place to define and support the team function?
8. Does the team have sufficient resources to achieve the desired health outcomes?
9. Who will coordinate care, manage the team, and ensure efficient and effective communication among team members and across teams?

others (usually physicians); they must adjust the levels of their protection to reflect the higher risk profiles they will be adopting. This may lead to higher liability protection costs – funding authorities should take these costs into consideration.

- Regulated professionals must address issues related to potential increased personal risk and liability arising from non-regulated professionals prasticing within collaborative care teams.
- Adequate provisions must be made to cover any potential cases of joint and several liability – this is when one or more parties are found responsible for having caused injury to another and the plaintiff may recover full compensation from the provider most able to pay, even if that recovery is out of proportion to the degree of liability.

VICARIOUS LIABILITY

Vicarious liability is a risk posed when health professionals are employees of an individual or other legally recognized entity (such as a corporation or a partnership). The employer (for example, a hospital, a physician or a group of physicians) may be liable for the negligence of employees. Depending on the composition and functioning of the collaborative team, vicarious liability may also be extended to other team members (CMPA).

We all have a role and responsibility in engaging the system. Through open communication, active listening and valuing what is heard, we can truly collaborate and generate sustainable solutions. These are the shared values that build trust and encourage people to access care. This is at the heart of what can transform our medical system. – Dr. Maria Patriquin, Living Well Integrative Health Center

References

COLLABORATIVE PRACTICE

Baik, D. (2016, December). Team–Based Care: A Concept Analysis. In *Nursing Forum*.

Kelly, D.V., Bishop, L., Young, S., Hawboldt, J., Phillips, L., & Keough, T.M (2013). Pharmacist and physician views on collaborative practice: Findings from the community pharmaceutical care project. *Canadian Pharmacists Journal/Revue des Pharmaciens du Canada* 146: 218.

Nicholson, C., Jackson, C., & Marley, J. (2013). A governance model for integrated primary/secondary care for the health-reforming first world–results of a systematic review. *BMC health services research, 13*(1), 528.

Nolte, J., & Tremblay, M. (2005). *Enhancing interdisciplinary collaboration in primary health care in Canada.* Enhancing Interdisciplinary Collaboration in Primary Health Care. http://tools.hhrrhs.ca/index.php?option=com_mtree&task=att_download&link_id=5305&cf_id=68&lang=en

Primary Health Care, NSHA (2017). *Strengthening the Primary Health Care System in Nova Scotia. Evidence synthesis and guiding document for primary care delivery: Collaborative family practice teams and health homes.* Nova Scotia: Primary Health Care, Nova Scotia Health Authority.

The College of Family Physicians. (2011). *A Vision for Canada Family Practice – The Patient's Medical Home.* http://www.cfpc.ca/A_Vision_for_Canada/

Valaitis, R., McCarthy, J., Macdonald, M., Wong, S., Martin-Misener, R., & Akhtar-Danesh, N. (2012). Strengthening Primary Health Care through Primary Care and Public Health Collaboration Final Report for CFHI. *Ottawa: Canadian Foundation for Healthcare Improvement (CFHI).*

World Health Organization. (2010). Framework for Action on Interprofessional Education & Collaborative Practice. http://www.who.int/hrh/nursing_midwifery/en/

PAYMENT MODELS

Canadian Medical Association (2017) *Joule: The Essential Guide to a successful practice. New in practice 2017.*

College and Association of Registered Nurses of Alberta (CARNA). (2011). *Primary Care: Vision, Roles and Opportunities.* http://www.nurses.ab.ca/content/dam/carna/pdfs/DocumentList/PositionStatements/PrimaryCare_Jan2011.pdf

Doctors Nova Scotia (2017). Physicians' Recommendations to Improve Primary Care in Nova Scotia Fixing Nova Scotia's Primary Health Care Problem: Physicians' Recommendations to Improve Primary Care in Nova Scotia. http://www.doctorsns.com/site/media/DoctorsNS/primary-care-position.pdf

The College of Family Physicians of Canada (2016) *Best Advice: Physician Remuneration in a Patient's Medical Home.* http://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-physician-remuneration-patients-medical-home/

The College of Family Physicians of Canada (2017) *Best Advice: Team-based Care in the Patient's Medical Home.* http://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-team-based-care-patients-medical-home/

Wranik, D., Hanrahan, K., & Unit, I. C. (2012). *The Compensation and Management of Interdisciplinary Primary Health Care Teams in Alberta*. http://primaryhealthcareteams.ca/wp-content/uploads/2016/07/Report-2-Interdisciplinary-teams-in-Alberta-copy.pdf

Wranik, D., Korchagina, M., Edwards, J., Levy, A., Katz, A. (2015). *How Best to Pay Interdisciplinary Primary Care Teams? Funding and Remuneration: A Framework and Typology*. http://primaryhealthcareteams.ca/wp-content/uploads/2013/10/HRPA-Final-Report.pdf

STRUCTURAL CONSIDERATIONS

American Medical Association. (2017). STEPSforward. *Optimizing space in medical practices Design for meaningful and efficient patient visits*. https://www.stepsforward.org/Static/images/modules/18/downloadable/Space_optimization.pdf

Canada Health Infoway. (n.d.) *Get the Facts: Nova Scotia Peer Network.* https://www.infoway-inforoute.ca/en/component/edocman/1186-nova-scotia- peer-network-get-the-facts/view-document

Canadian Medical Association. (2017). Joule: The Essential Guide to a successful practice. New in practice 2017.

Canadian Medical Association. (2012). *Module 8: Physician Remuneration Options*. https://www.cma.ca/En/Pages/pmc-modules.aspx

Canadian Medical Association. (2017). Physician Workforce Survey. http://cma.andornot.com/en/surveydata/default.aspx

Canadian Nurses Association. (n.d.). *Primary Care Toolkit*. https://www.nurseone.ca/en/tools/primary-care-toolkit

Conference Board of Canada, 2012. *Improving Primary Health Care Through Collaboration Briefing 2—Barriers to Successful Interprofessional Teams.* http://www.wrha.mb.ca/staff/collaborativecare/files/IPHCTC-Briefing2.pdf

Doctors Nova Scotia (n.d.). *Business of Medicine: Support for a Healthy Practice – Managing Your Practice Lesson 4 Establishing a cost-shared practice*. http://www.doctorsns.com/site/media/DoctorsNS/BOM-C2-L4-costsharedpractice.pdf

Doucette, K. (2016). Nova Scotia's new online portal will deliver health test results to smartphones. *The Canadian Press*. https://www.thestar.com/news/canada/2016/07/28/nova-scotias-new-online-portal-will-deliver-health-test-results-to-smartphones.html

Goldman, J., Meuser, J., Rogers, J., Lawrie, L., & Reeves, S. (2010). Interprofessional collaboration in family health teams An Ontario-based study. *Canadian Family Physician, 56*(10), e368-e374. http://www.cfp.ca/content/56/10/e368.short

Howard, M., Brazil, K., Akhtar-Danesh, N., & Agarwal, G. (2011). Self-reported teamwork in family health team practices in Ontario Organizational and cultural predictors of team climate. *Canadian Family Physician, 57*(5), e185-e191. http://www.cfp.ca/content/57/5/e185.full?sid=70f607bd-60b9-4928-98a6-c836195f3475

McLaren, S. (2010). *Successful EMR adoption: optimizing your workflow.* https://www.infoway-inforoute.ca/en/resource-centre/advanced search?q=Successful+EMR+adoption%3A+optimizing+your+workflow

Nova Scotia Health and Wellness. (2016). Patient-focused Primary Health Care: Design Guide for Infrastructure Supporting Collaborative Health Care Teams. Nova Scotia Health and Wellness.

PWC (2013). *The emerging benefits of electronic medical record use in community-based care. Canada Health Infoway.* www.infoway-inforoute.ca/en/component/edocman/1225-the-emerging-benefits-of-electronic-medical-record-use-in-community-based-care-executive-summary/view-document?Itemid=101

The College of Family Physicians. (2011). *A Vision for Canada Family Practice – The Patient's Medical Home.* http://www.cfpc.ca/A_Vision_for_Canada/

The College of Family Physicians of Canada. (2016). *Check your practice: Adopting EMRs in the Patient's Medical Home.* http://patientsmedicalhome.ca/files/uploads/EMR_QuickREF_ENG_July16.pdf

World Health Organization. (2010). Framework for Action on Interprofessional Education & Collaborative Practice. http://www.who.int/hrh/nursing_midwifery/en/

PROVIDING CARE AS A COLLABORATIVE TEAM

Alberta College of Family Physicians. (2011). Medical Home Leadership Forum Synopsis: December 3, 2011 proceedings. https://www.acfp.ca/wp-content/uploads/2014/04/2012MHLF_Synopsisweb.pdf

Canadian Interprofessional Health Collaborative (CIHC). (2010). A National Interprofessional Competency Framework. http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210r.pdf

Denis, J. L., Baker, G. R., Black, C., Langley, A., Lawless, B., Leblanc, D., ... & Tre, G. (2013). Exploring the dynamics of physician engagement and leadership for health system improvement: Prospects for Canadian Healthcare Systems. *Report prepared for the Canadian Foundation for Healthcare Improvement. Ottawa, Canada: Canadian Foundation for Healthcare Improvement.*

Nicholson, C., Jackson, C., & Marley, J. (2013). A governance model for integrated primary/secondary care for the health-reforming first world–results of a systematic review. *BMC health services research, 13*(1), 528.

Raelin, J. (2004). Preparing for Leaderful Practice. *T+D*, 15357740, Mar2004, Vol. 58, Issue 3 https://www.umanitoba.ca/admin/human_resources/lds/media/Preparing_for_Leaderful_Practice.pdf

The College of Family Physicians of Canada. (2017). *Best Advice: Team-based Care in the Patient's Medical Home* http://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-team-based-care-patients-medical-home/

Valaitis, R., McCarthy, J., Macdonald, M., Wong, S., Martin-Misener, R., & Akhtar-Danesh, N. (2012). *Strengthening Primary Health Care through Primary Care and Public Health Collaboration Final Report for CFHI.* Ottawa: Canadian Foundation for Healthcare Improvement (CFHI).

Virani, T. (2012). *Interprofessional collaborative teams.* Canadian Health Services Research Foundation.

LIABILITY ISSUES

Prada, G., Swettenham, J., Ries, N., & Martin, J. (2007). *Liability Risks in Interdisciplinary Care: Thinking Outside the Box.* Toronto, Ontario, Canada: Conference Board of Canada.

The Canadian Medical Protective Association. (n.d.). *Collaborative Care: A Medical Perspective.* https://www.cmpa-acpm.ca/static-assets/pdf/advice-and-publications/handbooks/06_collaborative_care-e.pdf

TOOLS AND RESOURCES

Collaborative Practice: Meaning, Models, Benefits and Challenges

- A Vision for Canada Family Practice – The Patient's Medical Home http://www.cfpc.ca/A_Vision_for_Canada/
- Strengthening the Primary Health Care System in Nova Scotia | Evidence Synthesis and Guiding Document for Primary Care Delivery: Collaborative family practice teams & health homes http://www.nshealth.ca/files/strengthening-primary-health-care-system-nova-scotia
- Collaborative Family Practice Team Information http://www.nshealth.ca/collaborative-family-practice-teams
- Collaborative Care – Information Sheet for Patients by Dr. Maria Patriquin (see Appendix A)
- Important Conceptualizations in Transformation to a Collaborative Model of Primary Health Care Provision by Dr. Maria Patriquin (see Appendix A)
- Contract Deliverables Template, Department of Health and Wellness (see Appendix A)
- Physician Leadership Development Program Collaborative Practice Action Learning Project http://www.doctorsns.com/en/home/practiceresources/Business-of-Medicine/Physician-Leadership/physician-leadership-development-program/action-learning-projects.aspx

Payment Models

- Sample Alternative Payment Plan Contract (see Appendix A)
- The College of Family Physicians of Canada, 2017) Best Advice Guide: Physician Remuneration in a Patient's Medical Home http://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-physician-remuneration-patients-medical-home/

Structural Considerations

- Sample Cost-sharing and Operating Agreement
  This sample contract outlines the information covered in a cost-sharing agreement among team members.

- Doctors Nova Scotia's EMR Advisors
  EMR advisors give guidance and advice to physicians about all aspects of electronic medical records.
  Brent Andrews
  Physician Advisor for IWK, Central, Western and Northern (Colchester County and Municipality of East Hants) zones
  902-225-8577 (cell)
  brent.andrews@doctorsns.com
  Derek Stewart
  Physician Advisor for Eastern and Northern (Cumberland and Pictou Counties) zones
  902-565-4568 (cell)
  derek.stewart@doctorsns.com

- Electronic Records Handbook. Canadian Medical Protective Association (2014). https://www.cmpa-acpm.ca/static-assets/pdf/advice-and-publications/handbooks/com_electronic_records_handbook-e.pdf
  This handbook provides information about selecting an appropriate EMR, regulation of EMRs, patient consent and rights to access, security and privacy issues, maintaining data integrity, sending and transferring records, destroying and disposing of records, data sharing and inter-physician arrangements, and emerging issues.

- Check your practice: Adopting EMRs in the Patient's Medical Home. The College of Family Physicians of Canada (2016). http://patientsmedicalhome.ca/resources/best-advice-guides/best-advice-guide-adopting-emrs/
  This guide provides family physicians with concrete suggestions on what to consider when adopting an EMR in a primary care practice.

Providing Care as a Collaborative Team

- Patient Medical Home Guiding Principles
  http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/PMH_A_Vision_for_Canada.pdf
  Guiding principles for offering patients a broad scope of services carried out by teams or networks of providers in the PMH.

- Assessment of Interprofessional Team Collaboration Scale (AITCS)
  http://swostroke.ca/wp-content/uploads/2015/12/AITCS-May-09.pdf
  The AITCS is a diagnostic instrument that is designed to measure the interprofessional collaboration among team members.

- Collaborative Practice Assessment Tool (CAPT)
  http://old.healthsci.queensu.ca/assets/CPAT/Collaborative%20Practice%20Assessment%20Tool%20(CPAT).pdf
  The Collaborative Practice Assessment Tool (CPAT) was designed to assess perceptions of constructs of collaborative practice identified in the literature.

- Team Climate Inventory (TCI)
  http://onlinelibrary.wiley.com/doi/10.1002/%28SICI%291099-1379%28199805%2919:3%3C235::AID-JOB837%3E3.0.CO;2-C/abstract
  The Team Climate Inventory (TCI) is a structured self-report measure designed to assess the "facet-specific climate for innovation within groups at work" based on four dimensions: vision, participant safety, task orientation and support for innovation.

- Clare Medical Centre – Office Administration and Patient Attendant Procedure Manual
  The Clare Medical Centre is willing to share its office procedure manual, which provides detailed information about work flow. Please contact Office Manager Janice Bilodeau by email at jbilodeau@clarehealthcentre.ca or by telephone at 902-645-2777.

Liability Issues

- The Canadian Medical Protective Association (CMPA)
  www.cmpa-acpm.ca
  The CMPA provides professional liability protection for Canadian physicians in the form of advice and legal assistance and, when warranted, legal assistance for matters arising from a member's professional work. This includes advice and assistance in civil legal actions, regulatory authority (college) complaints, coroners' inquests and billing audits.

- The Canadian Medical Protective Association Collaborative Care: A Medical Liability Perspective
  https://www.cmpa-acpm.ca/static-assets/pdf/advice-and-publications/handbooks/06_collaborative_care-e.pdf
  This booklet identifies potential medico-legal risks and proposes solutions to mitigate those risks and addresses potential accountability and liability concerns which, if left unaddressed, may hinder the achievement of collaborative care goals. It also includes a 2005 CMPA/Canadian Nurses Protective Society Joint Statement on Liability Protection for Nurse Practitioners and Physicians in Collaborative Practice, as an example of a positive approach to many of the concerns.

Appendix A

Find the following resources online at www.doctorsNS.com > Contract & Practice Support > Collaborative Practice Tool Kit.

Appendix A – Tools and Resources

WHAT IS COLLABORATIVE PRACTICE?

- Collaborative Care – Information Sheet for Patients*
- Important Conceptualizations in Transformation to a Collaborative Model of Primary Health Care Provision*
  **created by Dr. Maria Patriquin, founder of Living Well Integrative Health Center*
- Template of DHW Contract Deliverables

PAYMENT MODELS

- Sample Alternative Payment Plan Contract

STRUCTURAL CONSIDERATIONS OF COLLABORATIVE PRACTICES

- Sample Cost Sharing and Operating Agreement