An Opportunity for Quality:

The Need for Better Evaluation of Family Health Teams in Ontario

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Abstract

In the past decade, primary care has undergone significant changes toward system improvement, which has improved patient outcomes and reduced costs. Family health teams (FHTs) were introduced in Ontario as part of primary care renewal. FHTs address a lack of capacity and integration among providers and service inaccessibility experienced by the population. We explore, the potential for positive impact of FHTs and the lack of built-in evaluation strategies to assess performance. We provide four suggestions to better support rigorous evaluation of FHTs. This commentary considers Ontario's efforts to improve capacity, quality and evaluation in primary care through FHTs.

Primary care deserves accolades. A key part of the health system, where for the past decade the only constant has been change, primary care has risen to the challenge and made great strides towards overall system improvement through innovative delivery models, positive technological changes and overall primary care renewal (Health Council of Canada 2005; Hutchison et al. 2011). Primary care has acted as a reliable, dependable and often overlooked foundation on which our health system is built (PCDC 2017). Recent challenges – from patient demand to system policies – have caused concern around the stability of primary care and family physicians (Glazier et al. 2012).

Primary care renewal started in Canada in the early 2000s with the Romanow Commission (Romanow 2002); improvement efforts have been paralleled around the world as an attempt to fix a global problem characterized by poor access, lack of standardized quality and insufficient funding (Government of Canada 2005; Starfield 2007). Although the process of primary care renewal has worked to patch cracks in the foundation, many underlying problems remain unresolved. Patients still do not have timely access to care (Health Quality Ontario 2017); quality of care across primary care is inconsistent, lacking or not properly measured (Docteur 2001); and funding for primary care remains insufficient (Dwyer 2018). Comprehensive primary care can have a significant impact on improving patient outcomes and on decreasing system costs (Hollander 2009). To maintain these benefits and sustain primary care's ability to do fundamental system work, continued resources and increased capacity are necessary, but current trends, political, professional and economic, are pointing us in a different direction.

Family health teams (FHTs) were created over a decade ago in Ontario as a solution to a lack of capacity and integration among primary care providers, and to address the growing need for increased access to care (Brown et al. 2016). Over 10 years of research and implementation work have gone into FHT development and proliferation in Ontario (Marchildon

and Hutchison 2016). This key innovation breathed new vitality into family medicine. Those involved in the development of FHTs should be commended for this, a proactive step towards strengthening primary care in Ontario and improving care for patients (Gocan et al. 2014; Rosser et al. 2010). However, challenges in FHTs remain. It is difficult to definitively say FHTs have improved system-level metrics, and we know that not all patients who stand to benefit from a team approach have access to a FHT model (Marchildon and Hutchison 2016). Further, the lack of certainty around provincial-level policies has waned the momentum of FHTs, causing frustration and uncertainty (Office of the Auditor General of Ontario 2017).

Evaluation of FHTs has also been a challenge. In other areas in healthcare, notably hospital care, patient outcomes and quality metrics tend to be more rigorously embedded (The Conference Board of Canada 2014) or mandated (MOHLTC 2011). However, because of a lack of pre-determined or embedded robust metrics in the development of FHTs, evaluation has been insufficient. We still do not have a comprehensive understanding of the FHT program across the province, despite being urged to by the recent Auditor General Report (Office of the Auditor General of Ontario 2017). There have been impressive attempts to support FHT performance, for example, the Quality Improvement and Innovation Partnership and Data to Decisions (D2D) (Stewart et al. 2015). D2D was developed by the Association of Family Health Teams of Ontario (AFHTO) to measure and improve the quality of care provided by FHTs (AFHTO 2018a; Wagner et al. 2017). Participation in these activities is often voluntary; those participating recognize the value of such initiatives and are striving to find ways to improve quality. There has also been progress towards understanding what facilitates FHTs' involvement in performance improvement activities, but these efforts also rely on those participating in quality improvement initiatives and thus are subject to selection bias (O'Brien et al. 2016). Research has shown that FHTs are most motivated to participate in D2D out of a desire for self-sustainability and greater political advocacy (AFHTO 2018a). It would be beneficial to everyone (providers, patients and the system) if the primary care sector was better supported to evaluate outcomes and generate widespread sharing of successes (Wagner et al. 2017). Evaluations are often expensive, time-consuming and require skilled capacity to do well. This is further complicated by election cycle; delayed decision-making and lack of initiative to implement change-oriented solutions (Glauser et al. 2016).

Variations in FHT performance often translate into variations in care and health outcomes, as well as variation in overall system cost (Howard et al. 2011). FHTs not performing well or costing "too much" can become a politicizing narrative and risk backtracking advancements of a perceived waste of public funds. We need timely and meaningful data that can be turned quickly into action, and we need to be able to provide feedback on the efficacy of those actions. We need innovative approaches for performing evaluation, which so far has largely been an academic exercise with very little follow-up or interventions (Portela et al. 2015).

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Even with increased evidence and locally derived data, there remains the challenge of using evidence to make decisions. Physicians increasingly face information overload coupled with high patient expectations (Gupta et al.2017). One of the most consistent findings in health services research is the gap between evidence and practice (Grimshaw et al. 2012). The difficulty of changing clinical practice is illustrated by the time lag between evidence and use in practice (Glauser et al. 2016). Traditionally, it has been assumed that healthcare providers have the time, energy and skills to assess primary research and the ability to introduce new practices in their working environment (Gupta et al. 2017). However, we know this is unrealistic and challenging to do (Alper et al. 2004). Compounding this is the fact that there are hundreds of clinical practice guidelines (CPGs) at play for a primary care provider at any point in time. Although guidelines help structure practice, they do not illustrate or convey how to implement a practice change in different patient scenarios (Gupta et al. 2016). Healthcare professionals interested in changing their practices often encounter barriers, be they organizational (lack of facilities or equipment), peer group (local standards of care not in line with the desired practice) or individual (knowledge, attitudes and skills [Grimshaw et al. 2002]). Practice change can disturb the status quo equilibrium, and healthcare professionals may face difficulties in changing practice and instead work to restore the "equilibrium" of the working environment. Changing clinical practice often means both learning new practices and un-learning or abandoning of old and outdated knowledge and practices (Ubel and Asch 2015). This is all happening in a complex, multi- and interdisciplinary setting where change is difficult and often politicized. Uncoordinated decision-making involving third parties (such as hospital management, physician colleagues and support staff) further complicates change when, for example, a physician incorporates a change into practice and key players do not (Malfair et al. 2016).

Call for Change

To improve capacity, quality and evaluation in primary care specific to FHTs, we have four system-level recommendations:

1. Expand the availability of staff that support quality improvement activities – clinicians cannot be expected to find the time (nor to have the skill and expertise) to do this on their own. There are approximately 35 funded quality improvement decision support specialists (and like positions) among 183 FHTs (AFHTO 2018b). This is insufficient to create sustainable quality improvement.
2. Require electronic medical record (EMR) vendors to include tools in their products that have updated CPGs as an integrated part of the system – putting the tools at clinicians' fingertips to support constant practice change and adaptation. EMR vendors should also work with providers to embed evaluation metrics into EMRs to be able to track use and outcomes of CPGs.
3. Continue to push for more meaningful and timely practice-level data and evaluation metrics to support change management and outcomes-based decision-making. There needs to be increased support for researchers to work collaboratively with practitioners to come up with effective and feasible evaluation methods. Targeted funding, knowledge brokering, and transparent decision-making are a few ways the Ministry can help.
4. Provide change management training for FHT leadership and support efforts to nurture capacity and skill. Build on the successes of activities that have already occurred in this regard and ensure that it is shared with others. Peer-to-peer learning and mentorship models can support this and should be embedded in quality improvement expectations.

We also recommend that more research be conducted to understand what facilitates FHTs' involvement in performance improvement activities such as those suggested above. Research which focuses on who is not involved and understanding how to ensure a standard of quality in all FHTs.

We need to celebrate the successes of FHTs by looking at patient stories, by better understanding provider experiences and by accounting for the actual costs associated with (and system savings derived from) FHTs. Evaluations should identify FHTs that are performing to the full potential of the model and determine how to support the improvement of FHTs that are not. Evaluation of impact should include assessing FHTs influence at a population level, analyzing health outcomes and providing actionable recommendations to ensure sustainable impact.

Primary care is the bedrock of Canada's health system, the one constant from "cradle to grave" for people. We need to improve our evaluation of the current FHT approaches and celebrate the successes of the FHT model. We need to determine how to support and drive all FHTs to attain the success that we know can be achieved so that all patients can benefit from access to excellent primary care. HQ

References

Alper, B.S., J.A. Hand, S.G. Elliott, S. Kinkade, M.J. Hauan, D.K. Onion et al. 2004. "How Much Effort is Needed to Keep up With the Literature Relevant for Primary Care?" *Journal of the Medical Library Association* 92(4): 429–37.

Association of Family Health Teams of Ontario (AFHTO). 2018a. "D2D 5.1: Getting Started and Changing Gears." Retrieved May 13, 2018. <https://www.afhto.ca/highlights/d2d-5-1-getting-started-and-changing-gears/>.

Association of Family Health Teams of Ontario (AFHTO). 2018b. "Ontario Primary Care Teams: Better Care. Healthier Families. Best Value." Retrieved May 13, 2018. <https://www.afhto.ca/teams/>.

Brown, J. B., B. L. Ryan and C. Thorpe. 2016. "Processes of Patient-Centred Care in Family Health Teams: A Qualitative Study." *CMAJ Open* 4(2): E271. doi:10.9778/cmajo.20150128.

Docteur, E. 2001. "Measuring the Quality of Care in Different Settings." *Health Care Financing Review* 22(3): 59–70.

Dwyer, J. 2018, January 04. "Now, More Than Ever, We Need to Solve Ontario's Health-Care Crisis of Capacity." *The Globe and Mail*. Retrieved May 17, 2018. <https://www.theglobeandmail.com/opinion/now-more-than-ever-we-need-to-solve-ontarios-health-care-crisis-of-capacity/article37490512>.

Glauser, W., M. Nolan and J. Petch. 2016. "Why Aren't New Healthcare Models Studied More?" Health Debate. Retrieved June 1, 2018. <https://healthydebate.ca/2016/03/topic/health-care-models-evaluation>.

Glazier, R.H., A. Kopp, S.E. Schultz, T. Kiran and D.A. Henry. 2012. "All the Right Intentions but Few of the Desired Results: Lessons on Access to Primary Care from Ontario's Patient Enrolment Models." *Healthcare Quarterly* 15(3): 17–21.

Gocan, S., M.A. Laplante and K. Woodend. 2014. "Interprofessional Collaboration in Ontario's Family Health Teams: A Review of the Literature." *Journal of Research in Interprofessional Practice and Education* 3(3): 11–12. Retrieved June 5, 2018. <https://www.jripe.org/index.php/journal/article/download/131/84>. doi:10.22230/jripe.2014v3n3a131.

Government of Canada. 2005. "Primary Health Care and Health System Renewal." Retrieved May 17, 2018.< https://www.canada.ca/en/health-canada/services/primary-health-care/primary-health-care-health-system-renewal.html>/>.

Marchildon, G.P. and B. Hutchison. 2016. "Primary Care in Ontario, Canada: New Proposals after 15 Years of Reform." *Health Policy* 120(7): 732–38. doi:10.1016/j.healthpol.2016.04.010.

Grimshaw, J.M., M.P. Eccles, J.N. Lavis, S.J. Hill and J.E. Squires. 2012. "Knowledge Translation of Research Findings." *Implementation Science* 7(1): 50. doi:10.1186/1748-5908-7-50.

Gupta, D.M., R.J. Boland and D.C. Aron. 2017. "The Physician's Experience of Changing Clinical Practice: A Struggle to Unlearn." *Implementation Science* 12(1): 28. doi:10.1186/s13012-017-0555-2.

Gupta, S., N. Rai, O. Bhattacharrya, A.Y. Cheng, K.A. Connelly, L. P. Boulet, et al. 2016. "Optimizing the Language and Format of Guidelines to Improve Guideline Uptake." *Canadian Medical Association Journal* 188(14): E362–68. doi:10.1503/cmaj.151102.

Health Council of Canada. 2005. "Health Care Renewal in Canada: Accelerating Change." Retrieved May 15, 2018. <https://healthcouncilcanada.ca/files/2.48-Accelerating_Change_HCC_2005.pdf>.

Health Quality Ontario (HQO). 2017. "Primary Care: Timely Access." Retrieved June 3, 2018. <https://qualitycompass.hqontario.ca/portal/primary-care/Timely-Access?extra=pdf>.

Hollander, M.J., H. Kadlec, R. Hamdi and A. Tessaro. 2009. "Increasing Value for Money in the Canadian Healthcare System: New Findings on the Contribution of Primary Care Services." *Healthcare Quarterly* 12(4): 32–44.

Howard, M., K. Brazil, N. Akhtar-Danesh and G. Agarwal. 2011. "Self-reported Teamwork in Family Health Team Practices in Ontario: Organizational and cultural predictors of team climate." *Canadian Family Physician* 57(5): e185–91.

Hutchison, B., J.F. Levesque, E. Strumpf and N. Coyle. 2011. "Primary Health Care in Canada: Systems in Motion." *Milbank Quarterly* 89(2): 256–88. doi:10.1111/j.1468-0009.2011.00628.x.

Malfair, S., A. Hecke, J. Hellings, G. Bodt and K. Eeckloo. 2016. "The Impact of Stakeholder Involvement in Hospital Policy Decision-Making: A Study pf the Hospital's Business Processes." *Acta Clinica Belgica* 72(1): 63–71. doi:10.1080/17843286.2016.1246681.

Portela, M.C., P.J. Pronovost, T. Woodcock, P. Carter and M. Dixon-Woods. 2015. "How to Study Improvement Interventions: A Brief Overview of Possible Study Types." *BMJ Quality & Safety* 24(5): 325–36.

Primary Care Development Corporation (PCDC). 2017. "Primary Care is the Foundation of the Health Care System." Retrieved May 22, 2018. <https://www.pcdc.org/what-we-do/policy-advocacy/primary-care-foundation-health-care-system/>.

O'Brien, P., M. Aggarwal, L. Rozmovits, M. Whittaker and E. Philip. 2016. "The Teaming Project – Learning from High-Functioning Interprofessional Primary Care Teams." Toronto, ON: University of Toronto, Department of Family and Community Medicine. Retrieved May 15, 2018. <https://www.dfcm.utoronto.ca/sites/default/files/The%20Teaming%20Project%20Report%202016-10-17.pdf>.

Office of the Auditor General of Ontario. 2017. "Annual Report 2017: Volume 1." Retrieved June 2, 2018. <http://www.auditor.on.ca/en/content/annualreports/arreports/en17/2017AR_v1_en_web.pdf>.

Romanow, R.J. 2002. "Building on Values: The Future of Health Care in Canada." Retrieved May 15, 2018. <http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf>.

Rosser, W.W., J.M. Colwill, J. Kasperski and L.Wilson. 2010. "Patient-Centered Medical Homes in Ontario." *New England Journal of Medicine* 362(3): e7. doi:10.1056/NEJMp0911519.

Starfield, B. 2007. "Global Health, Equity and Primary Care." *Journal of the American Board of Family Medicine* 20(6): 511–13. doi:10.3122/jabfm.2007.06.070176.

The Conference Board of Canada. 2014. "Final Report: An External Evaluation of the Family Health Team (FHT) Initiative." Retrieved May 22, 2018. <https://www.researchgate.net/profile/Dale_Mcmurchy/publication/273866011_An_External_Evaluation_of_the_Family_Health_Team_FHT_Initiative/links/5514098a0cf283ee0834a0f2/An-External-Evaluation-of-the-Family-Health-Team-FHT-Initiative.pdf>.

Ubel, P.A. and D.A. Asch. 2015. "Creating Value in Health by Understanding and Overcoming Resistance to De-Innovation." *Health Affairs* 34(2): 239–44. doi:10.1377/hlthaff.2014.0983.

Wagner, D.J., J. Durbin, J. Barnsley and N.M. Ivers. 2017. "Beyond Quality Improvement: Exploring Why Primary Care Teams Engage in a Voluntary Audit and Feedback Program." *BMC Health Services Research* 17(1): 803. doi:10.1186/s12913-017-2765-3.

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