Processes of Patient-Centred Care in Family Health Teams: Access, Continuity, and Coordination

Judith Belle Brown, PhD*

Bridget L. Ryan, PhD**

Cathy Thorpe, MA***

*Department of Family Medicine, Schulich School of Medicine and Dentistry and School of Social Work, King's University College, Western University, Western Centre for Public Health and Family Medicine, 1151 Richmond Street, London, ON N6K 3K7

**Department of Family Medicine and Department of Epidemiology and Biostatistics, Schulich School of Medicine and Dentistry. Western University, Western Centre for Public Health and Family Medicine, 1151 Richmond Street, London, ON N6K 3K7

***Department of Family Medicine, Schulich School of Medicine and Dentistry. Western University, Western Centre for Public Health and Family Medicine, 1151 Richmond Street, London, ON N6K 3K7

Corresponding author: Judith Belle Brown, PhD; Department of Family Medicine, Schulich School of Medicine and Dentistry and King's University College, School of Social Work. Western University, Western Centre for Public Health and Family Medicine, 1151 Richmond Street, London, ON N6K 3K7; email: Judith.Brown@schulich.uwo.ca

KEY WORDS: access, continuity, coordination, patient-centred care, Family Health Teams, qualitative methodology, grounded theory

FUNDING

The authors acknowledge the funding and support of the Ontario Ministry of Health and Long-Term Care and the Ontario College of Family Physicians. The views expressed are those of the authors and do not necessarily reflect those of the Ministry or the College.

Processes of Patient-Centred Care in Family Health Teams: Access, Continuity, and Coordination

ABSTRACT

Background

Access, continuity, coordination of care and patient-centredness are core processes in the delivery of primary health care. They are essential deliverables of one model of primary care, Family Health Teams (FHTs) in Ontario. This paper describes these processes of care as enacted by FHTs.

Methods

This study used a grounded theory methodology to examine four processes of care in FHTs from the perspective of health care providers. Twenty practice sites were selected to represent maximum variation; e.g. location, year of FHT approval. Semi-structured interviews were conducted with each participant. A constant comparative approach was used to analyze the data.

Findings

The final sample consisted of 110 participants from 20 FHTs with interprofessional team members. Participants' described how their FHT ensured timely access, pursued continuity and coordination in their delivery of care and strived to provide patient-centred care. Participants in all teams articulated a commitment to and an execution of access, spontaneously expressing the importance of access to mental health services. Continuity of care was linked to both access and patient-centred care. Coordination of care by the team was perceived to reduce unnecessary walk-in clinic and emergency department visits, and facilitated a smoother transition from hospital to home. Patient-centred care was provided through a variety of means forging the links among the processes of care described above.

Interpretation

These four processes of patient care were inextricably entwined. Patient-centred care was the common thread that wove them together, and these processes in turn served to enhance the delivery of patient-centred care.

INTRODUCTION

A recent report by the European Commission described a primary care system as "universally accessible, integrated, person-centred, comprehensive … and provided by a team of professionals accountable for addressing a large majority of personal health needs" [1]. These processes of care were heralded by authors over a decade ago [2, 3] and continue to be emphasized in current research [4-7]. In particular, access, continuity, coordination of care and patient-centredness are hallmarks of primary care models worldwide [8].

One such model of primary care are interprofessional Family Health Teams (FHTs) in Ontario which were initially launched in 2005. Now numbering 200, FHTs provide care for more than three million Ontarians, approximately 22% of the provincial population [9, 10]. These FHTs include family physicians and other primary care professionals, most commonly nurses, nurse practitioners, social workers, dietitians, and pharmacists, as well as administrative support staff [10]. The principal goals of the provincially funded FHTs are improved access, quality and comprehensiveness of care (with an emphasis on chronic disease management, health promotion and disease prevention), interdisciplinary teamwork, patient engagement, and integration and coordination of care [10].

As FHTs approach their tenth anniversay, it is timely to examine how specific processes of care are being delivered. This paper describes the following processes of care: access; continuity; coordination of care; and patient-centred care as enacted by FHTs.

METHODS

We conducted a mixed methods study to examine teamwork in FHTs [11]. This portion of the study used a grounded theory methodology to examine specific processes of care for patients in FHTs from the perspective of their health care providers [12].

Participant Recruitment

Twenty FHT practice sites were recruited by the Ontario College of Family Physicians (OCFP), and were selected to represent maximum variation in terms of location (urban, rural), year of FHT approval, mix of health professionals, and practice configuration (e.g. single site, multi-site). The interview participants were recruited from each of the 20 participating practices, most often by the Executive Director or office manager. They were asked to recruit participants who would reflect the overall team composition. Informed consent was received from each participant before the interview began.

Data Collection

A semi-structured in-depth interview was conducted with each participant by one of the three authors. Interview questions included: *"Describe how your team provides timely access?" "How do you know when your team is providing patient-centred care?*" Further questions explored participants' ideas and perceptions regarding continuity, coordination of care including transitions from hospital to home. Interviews were conducted at the practice site and lasted 30 minutes on average. Interviews were audio-recorded and transcribed verbatim.

Data Analysis

The data were analyzed utilizing three specific steps: (1) open coding, (2) axial coding, and (3) selective coding [12]. In the first phase of the analysis, each transcript was independently

reviewed and coded by three researchers to determine the key concepts emerging from the data. The researchers then met to examine their independent coding, culminating in a consensus that informed the development of the coding template and the axial coding. The next iteration of the analysis, using selective coding, involved generation of summaries for each main theme with exemplar quotes.

Trustworthiness and Credibility

The trustworthiness and credibility of the analysis was insured by: audiotaping and verbatim transcripts; independent and team analysis; and detailed field notes following each practice visit. A commitment to reflexivity considered how the researchers' professional backgrounds, particularly in how the data were coded and interpreted, could influence the findings [13].

Ethics Approval

Ethics approval was received from The University of Western Ontario's Review Board for Health Sciences Research Involving Human Subjects.

FINDINGS

Final Sample

The final sample consisted of 110 participants from 20 FHT sites. Team size ranged from 9 to 80 team members. Participant demographics are described in Table 1.

Overview of Findings

Participants' descriptions of how their FHT ensured timely access, pursued continuity and coordination in their delivery of care and strived to provide patient-centred care revealed how

these four processes of patient care were inextricably woven together. With this in mind, each process is described below.

Access

Participants in all teams articulated a commitment to and an execution of access. Teams approached access in various ways. Some teams offered advanced access: *"We have amazing access and so the way that we do that is we have an advanced access schedule, so basically anybody who needs to get in today, gets in today."* Other teams provided access in what could be termed "hybrid access models" where within the teams, access could include extended hours, or open space in the physician's or nurse practitioner's appointment schedule. Access was described as the following:

> *If they cannot get in to see their physician then they can come and see one of the Nurse Practitioners or we have on-call hours as well, from 5 – 8, Monday to Friday, and on Saturday.*

Participants sponteneously expressed the importance of access to mental health services in FHTs. *"We're trying to offer daytime and evening appointments in mental health … I might see someone … on the same day they're seeing their doctor …. it's one visit for them instead of multiple visits."* Access was not only described as the availability of mental health services in general, but also responsiveness to acute crises identified by other providers. *"When a patient comes in and they're in a mental health crisis, I can go directly and speak to one of the Social Workers and say … 'this is what's going on, these are the issues, I need these resources', so they're right there."* The provision of mental health services was viewed as an alternative to

services in the community with long waiting lists and additional cost. *"I think our patients are just so appreciative of the tremendous services … in particular, mental health, which is just so expensive, and so dear in the community.*"

However, the concern about long waiting lists was now beginning to impact the provision of mental health services at the sites for two primary reasons. The first reflected how the demand had been exponentially growing: *"I think it's always going to be a question of demand exceeding supply, sadly."* The second reason was the tension occurring between the provision of short-term versus long-term psychotherapy:

> *It's an ethical thing* [in terms of duration of care]. *You want to do good work but on the other side, if you're keeping somebody too long* [in therapy]*, then somebody* [else] *isn't getting any care. So it's a balancing act.*

Despite these challenges, having mental health counsellors affiliated with the team was highly valued*. "Definitely the Social Worker is the biggest bang for the buck, in terms of having them on hand to give us a hand to manage patients."*

Continuity

The findings revealed a link between access and continuity: *"Advanced access is a tool that ensures continuity. If my patients don't need to see the doctors on call all the time because they can see me, then that's continuity"*. However, some participants acknowledged the fine balance between providing access while ensuring continuity: *"Their follow-up is with their own provider. So that balance of continuity and access I think is very balanced here."*

Continuity of care and patient-centred care were also linked as the following participant

articulated:

> *I think that continuity of care goes closely with patient-centred care because if you have a patient coming in having to tell their story over and over and over to different people that makes it difficult for everyone … they've shared their story with me and they've got to know me and trust me and we've developed a relationship so they have that continuity.*

Continuity of care was often described as "one stop-shopping":

> *It's basically one stop shopping here we have social work … RT, [and] the pharmacist. … Patients don't have to come back, or I don't have to say to them 'You need to book another appointment'. They are right there.*

Working as a team was viewed as enhancing continuity. *"Anytime you can put more than one discipline together in the same building, the continuity and quality of the care should ideally be increased*." Furthermore, continuity and provider collaboration could improve patient care and ultimately patient outcomes.

> *Continuity of care or collaboration of care, our FHT team supports that 100% so their aim is not to "take over" a patient from a physician, their aim is to lend a hand and extend the care for the patient on the behalf of the physician. Collaboration is really important so they work together as a team to support that patient's health.*

Patients needed to be educated about how continuity was ensured through communication of their care through the Electronic Medical Record (EMR).

> *You* [the patient] *needed to be seen but you worked until 5 o'clock, you could call and make an appointment to go to the after-hours clinic. It may not be with your physician or your NP or at your site, but it doesn't matter* [because] *whatever the issue is, the doctor can open up your chart* [in the EMR] *and see* [what happened].

Coordination

Participants perceived that the care they were now able to provide through an interdisciplinary team approach reduced unnecessary walk-in clinic and emergency department visits, and

facilitated a smoother transition from hospital to home. "*We set certain goals for our family health team … We've pretty much come down to zero with outside use [walk-in clinics] … our next big goal is we're trying to reduce ER visits*."

Some teams were able to combine team members' scopes of practice in enacting mechanisms to support and enhance patient transitions:

> *As for hospital discharges, we do have an organized system. So for example, a patient has been in the hospital for a week or two and has been discharged, the doctor will know within 48 hours and either myself or the nurse will call and follow up with the patient once they've been discharged home. Usually within the first couple of days they will have a follow up appointment with one of the doctors here but in the meantime we always call to see if there's any problems – "Do you have a follow up appointment booked? Do you have any concerns about your medication? Would you like our pharmacist to call you because now they've changed all your medications around? Do you have enough care at home?"*

However, challenges were encountered when teams were not notified about their patients' discharge from hospital. *"The transition from hospital to home and that care that needs to be involved is weak right now. There isn't a strong link. We don't know when our patients are in the hospital."* Despite these challenges, teams continued to strive for optimal patient transitions. "*The transitions of care … has to be a priority because it accounts for a lot of mistakes and needless consequences."*

Participants articulated how collaborative interdisciplinary practice facilitated coordination of patient care.

> *"We collaborate together. It is really a step forward ... Sometime we do joint home visits ... If I know the patient, or I have seen the patient and she [other health care provider] hasn't, a lot of time I will go out with her intiallly. She may be a stranger but it is a way*

to [indicate] this is my team member and a way to show the patient and the family that we do work together."

Patient-Centred Care

Patient-centred care was provided through a variety of means and forged the links among the processes of care described above. Practical and instrumental activities reflecting patient-centred care included improved access and continuity, and attention to issues of coordination and smooth transitions in care.

I think what's probably patient-centred is certainly the accessibility…We often hear from patients really appreciating the availability of care so I think that's very patient-centred. We're trying to offer day time and evening appointments in mental health – I think that's patient- centred.

Being patient-centred was also linked to having access to a variety of health care professionals on the team. "*What's fabulous about our team is that we really provide holistic care. Having all the different health care professionals here and being able to refer to them is a real luxury… "*

Prevention and health promotion activities inherent to patient-centred care were revealed in the following quotation:

Having the client play an active role in their health care, so instead of saying, "Okay, you need to do this, and you need to take care of this," we do a lot of motivational interviewing with the client around what their concerns are, what their goals are and what support they would like.

Being patient-centred was also described as providing care that included an understanding of the whole person.

The majority of us in the group will really genuinely bring up the patient perspective, patient issue, and all of the demographics and psychosocial issues around that patient and then it's clear to me that we're really trying to be very patient focused.

INTERPRETATION

This study explored four processes of care: access, continuty, coordination and patient-centred care. While these processes have been noted in prior research on FHTs, what is unique in the current study is how they are inextricably woven together [5-7]. In particular was how patient-centred care was the common thread that wove the other processes together, and how they in turn served to enhance the delivery of patient-centred care. For some participants, patient-centred care was more instrumental and included improved access and maintainenance of continuity within the team setting. Also, coordination and facilitation of transitions of care were not boiler-plate but rather geared to patients' specific needs and preferences, hallmarks of patient-centred care [14]. Other participants highlighted the patient-provider relationship, articulating a commitment to caring for the whole person not just the disease, a basic tenet of patient-centred care [14].

Improved access to care is a central mandate for FHTs and this study, as well as other research [5, 15, 16], provide evidence that this is being achieved albeit through various approaches. Our participants' unsolicited emphasis on the unique access to mental health services within their FHTs, as "added value", was a new and important finding. Prior research on the integration of mental health serivces within primary care practices has been limited to the experiences of shared care models in limited geographic locations [15, 16] whereas our findings reflect 20 FHTs across the province.

Having mental health services available extended beyond accessibility to include timely responses to patients in crisis. However, given the tremendous demand for mental health services the need was overwhelming the ability to provide timely access, resulting in long waiting lists. This issue requires remediation and might be addressed through creative service provision such as Cognitive Behavioural Therapy group sessions for persons with anxiety. Naysayers of interdisciplinary team work have anecdotaly warned that continuity of care will be forfeited in this setting. However our findings suggest the opposite – the team's commitment to ensuring continuity, while at the same time providing timely access, is achievable if there is active collaboration amongst the team members. Similar to prior work, patient education is also required to promote a seamless combination of access and continuity [5].

The study participants' commitment to providing coordinated care was, in many instances, directed toward reducing utilization of resources outside the FHT such as walk-in clinics or the emergency department. The greatest challenges the FHTs faced were the logistical and bureaucratic barriers they encountered. As a result it was often impossible to facilitate, for example, the transition from hospital to home, if the FHT had not been notified of the patient's discharge, let alone the admission. The changes required to ameliorate this situation are beyond the scope of each FHT and require significant systemic changes.

Only 20 FHTs out of the 200 FHTs in Ontario were examined and limit the transferability of the findings to all Ontario FHTs. However the participating FHTs had varied geography and team size. This study initiates an explanation of the links between these four processes of patient care, and the dynamic interaction amongst them. Further research may look at the impact of

these processes on patient outcomes and health care utilization. Other patient care processes such as patient engagement and comprehensiveness of care which are also goals for FHTs, were not examined and warrant further research.

References

1. Lancet Editorial. Making primary care people-centred: a 21st century blueprint. *Lancet* 2014;384:281.
2. Craigie FC, Hobbs RF III. Exploring the organizational culture of exemplary community health center practices. *Fam Med* 2004;36(10):733-8.
3. Grumbach K, Bodenheimer T. Can health care teams improve primary care practice? *JAMA* 2004;291(10):1246-12
4. Howard M, Brazil K, Akhtar-Danesh N, Agarwal G. Self-reported teamwork in family health team practices in Ontario. *Can Fam Physician* 2011;57:e-185-91.
5. Goldman J, Meuser J, Roger J, Lawrie L, Reeves S. Interprofessional collaboration in family health teams. *Can Fam Physician* 2010;56:e-368-74.
6. Conn GL, Oandasan IF, Creede C, Jakubovicz D, Wilson L. Creating sustainable change in the interprofessional academic primary care setting: an appreciative inquiry approach. *JRIPE* 2010;1:284-300.
7. Bodenheimer T, Ghorob A, Willard-Grace R, Grumbach K. The 10 building blocks of high-performing primary care. *Ann Fam Med* 2014;12(2):166-71.
8. Starfield B, Shi L, Macinko J. Contribution of primary care to health systems and health. *Milbank Q* 2005;83(3):457–502.
9. Hutchison B, Glazier R. Ontario's primary care reforms have transformed the local care landscape, but a plan is needed for ongoing transformation. *Health Aff* 2013;32(4):695-703.
10. Leading Practices Database - Family Health Teams [Internet]. Accreditation Canada. c2013 [cited 2014 Aug 25] Available: http://www.accreditation.ca/family-health-teams.

11. Brown JB, Ryan BL, Thorpe C, Markle EKR, Hutchison B, Glazier RH. Measuring teamwork in primary care: triangulation of qualitative and quantitative. *Families, Systems, & Health* 2015;March 2 [Epub ahead of print]. doi:10.1037/fsh0000109.
12. Charmaz K. *Constructing grounded theory: a practical guide through qualitative analysis*. Thousand Oaks, CA: Sage, 2014.
13. Malterud, K. Qualitative research: standards, challenges and guidelines. *Lancet* 2001;358:483-8.
14. Stewart M, Brown JB, Weston WW, McWhinney IR, McWilliam C, Freeman TR. *Patient-centered medicine transforming the clinical method.* London, UK: Radcliffe Publishing Limited, 2014.
15. Kates N, McPherson-Doe C, George L. Integrating mental health services within primary care settings: the Hamilton Family Health Team. *J Ambulatory Care Manage* 2011;34(2):174-82.
16. Haggarty JM, Jarva JA, Cernovsky Z, Karioja K, Martin L. Wait time impact of co-located primary care mental health services: the effect of adding collaborative care in Northern Ontario. *Can J Psychiatry* 2012;57(1):29-33.

Table 1 - Participant Characteristics

	Mean (SD)	Range
Age (years)	41 (11.6)	23 to 72
Time in current position (years)	5.5 (6.7)	<1month to 36
Sex	**N**	**%**
Male	21	19.0
Female	89	81.0
Total	110	100.0
Professional Affiliation	**N**	**%**
Family Physician	28	25.5
Nurse	16	14.5
Nurse Practitioner	12	10.9
Executive Director	11	10.0
Social Worker	11	10.0
Dietitian	9	8.2
Administrative Assistant	8	7.3
Management Personnel	6	5.5
Pharmacist	3	2.7
Psychologist	2	1.8
Physician Assistant	2	1.8
Occupational Therapist	1	0.9
Respiratory Therapist	1	0.9
Total	110	100.0