Interprofessional Primary Care Team Expansion Implementation Plan Toolkit

Alliance For Healthier Communities

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Contents

Introduction

The Ministry and Ontario Health have recently announced new and expanded teams. These teams will include Community Health Centres, Family Health Teams, Indigenous Primary Care Organizations and Nurse Practitioner-led Clinics and other new models.

A template was recently provided to organizations that received new funding and the completion of this template is a requirement. It will be important for you to consider what can be achieved within the funding amount received and include all activities related to implementation of the new/expanded team up to March 31, 2025.

This toolkit has been developed to assist you in the completion of this template however some of the details are specific to your centre and will require individualized planning.

Each section of the template have been included in this toolkit.

Most templates are due on **Wednesday, May 15th, but some are due sooner**. Seek assistance from your Ontario Health regional representative if necessary and ensure that all partners are involved in the completion of the template.

You will receive endorsement by the OH representative via email and instructions on all of some of the implementation steps outlined.

Strategic Considerations

Plan your new team based on what your community needs – You have received data from Ontario Health that will help you reflect on the types of providers that are required to best serve your communities. If you do not have access this data you can find it at Ontario Health Profiles

- Attachment is a key goal of this funding. It will be important to consider how staff working to full scope of practice will enable more clients to be registered to your organization
- Consider various roles and activities that roles can play such as system navigation/social prescribing

We understand that the expectations for this funding may exceed what feels reasonable, considering many received significantly less that what you asked for. However, it will be VERY IMPORTANT to try to see as many people as possible, as your implementation will be the test case for future investments into primary care. If, collectively, the sector is able to demonstrate success we will be in good stead to advocate for additional funding and supports for primary health care teams. Please consider that it is not solely attachment that will be counted. Group visits (primary care, mental health care, community support, social determinant of health etc) will be counted as well as the people that receive access to clinical care whether attached or not and of course those that you are able to attach through this new funding.

There seems to be different understanding of overhead/administrative costs, etc. Please complete the template with what is realistic – as long as you can meet your targets within the funding amount, I

believe OH will be open to hearing from you what will work best. Please approach this as a negotiation between partners with OH staff. If you encounter challenges, please let us know.

Participants

This table should include the list of names and contact information for the lead organization and all participating organizations that are involved in your team expansion. Co-design will be important so think about all providers, teams and organizations are identified.

If applicable, please indicate any First Nations, Inuit, Métis and urban Indigenous communities, organizations or health care system partners that are a part of your team/service. If this is an identified gap, money within this funding can be used to ensure Indigenous representation within your project.

Roles should include (if applicable):

- Lead organization
- Collaborating organization(s)
- Partner or affiliated organization(s)
- Ontario Health Team
- Stakeholder(s)
- Advisor(s)
- Consultant(s)
- Client, Community and/or family advisors
- Indigenous representation and/or organizations
- Others as appropriate for your IPCT

Governance

In this section you should describe the governance structure for the new/expanded teams and ensure to highlight that they are community governed.

In this section you might want to consider the following:

- Indicate if there is already a board/governance structure in place
- How board members are selected (using what criteria) and elected
- Describe your membership structure and if clients, community, community partners or others are members of your organization and if they have voting rights
- Include the number of board members
- Include information on board evaluations (the Alliance has board evaluation tools it can share if required)
- If you go through accreditation indicate some of the standards that your board is held accountable to
- Describe any clients, community members or people with lived experience on the board and how they are involved in decision making (describe communities that face barriers to access an health inequities and partners)
- Include information about advisory committees or ways that communities, clients/patients, families and/or caregivers provide input to the board
- Indicate the board's authority and responsibility for making decisions
- Indicate that you have by-laws and governance policies that guide the work of the board
- Indicate the governance model that the board follows
- Indicate that you do not have staff or providers on your board
- Indicate how you include community partners on the board or how they interact or inform the board
- Describe board committee structure including Executive Committee, Finance, Policy, Evaluation, Quality Improvement, etc.
- How will patients and family inform the process (if you have patients/clients on your board – mention this and include that they are involved in making decisions about the organization)
- Include information about a skills/lived experience matrix if you use one
- Describe any other relevant information about the board i.e. they must live in the catchment of the organization, etc
- If you don't have a board or governance structure in place describe how it will operate (using the above) once in place

In addition, you may want to consider creating a new advisory table or committee for the implementation of this expansion. This group should be responsible to the board. Suggested activities and responsibilities could include:

- Responsibility for guiding stakeholder engagement activities, selecting programs and services based on local need, the implementing service delivery, as well as supporting the measurement and evaluation
- Suggest that this group would be composed of partner health and social services agencies, key community stakeholders, primary care physician(s) from the Steering Committee identified below, internal staff, and IPC Team patients/clients.
- Consider including external Primary Care Providers without access to team-based care

**** Remember to include all of these people/organizations are included in your participant table.**

Interprofessional Primary Care Team Description and Benefits

In this section, describe the type of primary care services your new/expanded IPCT will be providing and how the team will work together to deliver care. You are also being asked to describe who will be hired and how these teams will increase access and attachment to primary care and benefit clients/patients. If you have more funding for more than one team/service type this must be completed for each team/service as per the template instructions.

IPCT Description

Describe the types of services you will be providing and which primary care team members will be involved in caring for patients.

Consider including:

- Describe all new staff (and roles) and types of planned services
- How all staff will work to full scope of practice ensuring that people unattached to primary care can be registered/enrolled
- Consider including roles such as system navigator/link worker to provide social prescribing. A guide to Social Prescribing can be found here. It has been demonstrated that incorporating this position into a team can significantly reduce the number of visits clients have their primary care practitioner, freeing up their time to see more people
- Include that all internal IPC team will use a shared EMR and work together in a mature interprofessional team
- Consider adopting the data entry standards that Alliance members use to assist with data collection and reporting
- Describe any collaboration activities that will ensure teams are working together (case conference, shared space/co-location, communication channels, dashboards, etc)
- If your plan includes registering new clients/patients consider the Better Health model first implemented in Merrickville/Smiths Falls (see Appendix A for more details)

Recruitment & Retention of Team Members

This section should include all of the new FTEs that will be hired by type – make sure to include all health professionals, management and administrative staff. For each staff type indicate whether they will be considered the Most Responsible Provider (MRP) for the provision of comprehensive primary care. The classification of MRP is typically applied to Physicians, Nurse Practitioners and sometimes RNs. Some organizations are including midwives and Indigenous Traditional Healers.

In this section you will also need to include your recruitment and retention strategy including timing, methods and who is responsible. While this funding is stated as one-time funding, we have a strong indication that this will become base funding in the future. It is advised that organizations recruit for permanent positions, with a strong clause that the position is dependent on funding. This is of course, up to individual organizations, but we know of many that are approaching recruitment in this way.

How will the new/expanded team increase access and attachment to primary care and benefit patients?

What new/expanded services will be implemented to serve the community and increase population health management approaches to primary care delivery?

- Describe team approach that has been planned for your expansion
- Discuss team-based approach and how you will maximize population health through the use of equity data/stratifiers. Highlight that sociodemographic and race-based data will be collected for all clients and used to plan and tailor service delivery

Provide a summary of how the team will optimize the attachment of new patients to a comprehensive care and/or enable access to an inter-disciplinary primary care team (for example though clinic policies or processes, team composition and function, expansion of access to IHPs to local primary care practices currently without teams).

- Consider discussing that all providers will work to full scope of practice
- Participate in a Learning Collaborative to expand access and increase efficiency
- Participate in the ICPT Community of Practice to share learning and innovation – We will be initiating this soon.
- If you are supporting primary care providers within your community consider including TeamCare/SPiN type initiatives to provide access to team-based care for people who may be enrolled elsewhere.
- Discuss Better Health (see Appendix A)
- Consider hiring or including system navigation or social prescribing into your HHR plan. This has been demonstrated to decrease visits with primary care providers and ensures that clients can access social and community services

How will the new/expanded team enhance patient experience and health outcomes?

- Improved access (primary care, IPCT, and social and community services)
- Improved self-reported physical and mental health and well-being (tools to demonstrate this are available from the Alliance)
- Discuss how you will actively be part of the ICPT evaluation and use the data and learnings to iteratively improve

Equitable Access to Care

This section includes a table that will describe the populations that experience health inequities, how you engaged with these groups and the impacts (both positive and negative)

Equity Deserving Populations

Describe the population(s) that experience inequities including, population(s) of focus or First Nations, Inuit, Métis and urban Indigenous peoples in your catchment area?

Impact on Health Equity

Describe how the team/services being provided impact health equity for identified equity-deserving population(s), population(s) of focus or First Nations, Inuit, Métis and urban Indigenous peoples?

- Consider including Improved access (primary care, IPCT, and social and community services)
- Discuss anti-oppression, trauma-informed and culturally safe care (The Alliance has a list of trainings and resources to assist with onboarding new staff and governors)
- Consider how you will tailor care based on potential barriers and how community members will be part of this planning to ensure appropriate
- Consider how you will equity stratify access and outcome measures to ensure any disparities in health can be identified

Engagement for Planning

- Describe all groups that experience health inequities that were part of the engagement process, examples include RR&N, Black, Francophone, 2SLGBTQ+ and others.
- Consider including all communities that were part of planning and any Community advisory Groups that help plan service delivery
- Specifically, highlight if you have engaged with any First Nations, Inuit, Métis and urban Indigenous communities, organizations or health tables in planning your service? Please describe which FNIMUI communities, organizations or health tables your organization engaged.
- If you have not done this (and it is applicable) describe how you plan to do this and who you will engage with. Consider working with the IPHCC to help you if you are a non-Indigenous Primary Care Organization
- If more engagement is necessary, identify how you will do this

Access to Care

- Will some populations of focus, other equity-deserving populations or First Nations, Inuit, Métis and urban Indigenous peoples potentially have different access to care or overall health outcomes than others? Describe why this is important using an equity lens (e.g. prioritizing service delivery to a specific equity-deserving group)

Unintended impact (positive/negative)

Are there other equity-deserving populations or First Nations, Inuit, Métis and urban Indigenous peoples which may experience unintended results, positive or negative?

For planning that does not directly engage or involve First Nations, Inuit, Metis and Urban Indigenous communities, have you considered potential positive or negative impacts on these communities?

Are there other intended or unintended consequences to consider:

- Demonstrating success working collaboratively across model types
- If link worker/system navigator roles are included: could access to this service improve long term outcomes for clients that have access to community and social supports (i.e. hospital diversion, LTC diversion, decreased need for mental health supports etc)?
- Could the implementation of this funding impact negatively on existing services the organization(s) are providing if the expansion is supported with enough resources?
- Could recruiting for these positions unintentionally impact other services in the community?
- Could serving communities that experience health inequities using the MHWB/MWHWB have other consequences that include community development, sense of belonging, other health or social issues solved?
- Could this funding enable you to leverage new or different funding?
- Could there be ethical issues if you are not able to meet the needs of the entire population or people that are requiring access to primary health care?
- Could this funding help the organization(s) to be stronger, more stable or have a bigger voice at the local planning tables?
- Will this funding assist with the participation in OHT or PCN development and implementation?

Indigenous Cultural Awareness and Safety Training

Include all Indigenous Cultural Awareness and Safety Training that your team has done and that you are planning for the new team. Include the proportion of staff who have completed this training.

Consider the IPHCC Anishinaabe Mino'Ayaawin Cultural Safety and Anti-Indigenous Racism in Health Care courses for new and existing staff. Also see the Guidance for Creating Safer Environments for Indigenous Peoples Toolkit.

Access to Indigenous Space and Services

Indicate here if your team/services offer access to dedicated Indigenous healing space and/or access to Elders, Traditional Healers and cultural ceremonies (e.g., a space for Indigenous patients and families to gather, smudging, care from an Elder or Traditional Knowledge Keeper, etc.)? Please *describe.*

Describe if your team/services include Indigenous Navigators, Indigenous Coordinators, or other related positions?

- If you are working with Indigenous populations and are not an Indigenous-led Primary Care Organization consider contacting IPHCC for potential partners.
- Also consider how you can partner or bring Indigenous organizations into the Implementation Plan if this has not been done already.

If any of the items above are applicable, you are being asked to do an impact assessment and answer the following questions.

Impact

What evidence are you using to assess the potential impact?

- Consider including client experience questions related to cultural safety in your usual survey

- Describe how you can equity stratify access and outcomes (using DOH and race-based data) to identify any disparities or unintended outcomes
- The Alliance has tools and resources available; you can make mention that you will utilize those resources

What is the probability of the predicted impact?

- Discuss how you have engaged with community groups, advisors and/or have existing relationships that will mitigate any negative impact
- Discuss the role and importance of community governance

What is the severity and scale of the impact?

- If there is an impact determine the severity and scale (how large)

Mitigation

How can you reduce or remove barriers and other inequitable effects?

Consider including

- The role of your community governed board of directors
- Any advisory groups that you will have to guide implementation
- Consider describing the trust you have with existing population you serve
- You will use data to continually monitor and improve and that this data will include DOH and race-based data that will ensure any health disparities or unequal access is identified
- Using a learning health system approach that will ensure you recognize an improvement isn't working quickly and readjust. You can include that you will participate in the Alliance's LHS program (if a member or joint member with IPHCC).

How can you maximize the positive effects or benefits that enhance health equity?

Considering including:

- That you will participate in the Alliance/IPHCC Community of Practice and share and learn from other IPCT sites
- Share within regional meetings and other networking opportunities
- Have providers/staff participate in learning collaboratives
- That you will work with the Alliance/IPHCC Implementation Lead

What specific changes do you need to make to the services, so it meets the needs of each equity-deserving community or First Nations, Inuit, Métis and urban Indigenous peoples you have identified?

Consider including:

- Work with the IPHCC and partner with any relevant local Indigenous organizations
- Support Indigenous Health in Indigenous Hands

How will you continue to engage and be accountable to equity-deserving populations, populations of focus or First Nations, Inuit, Métis and urban Indigenous peoples in designing and planning these changes?

- Take Indigenous Cultural Safety and Anti-Racism training
- Collect DOH and race-based data while working with IPHCC to understand and respect Indigenous Data Sovereignty
- Equity stratify all data to ensure equitable access and outcomes
- Engage with equity deserving populations to plan service delivery

Implementation Timeline

- Provide an outline of the activities and milestones that are planned to achieve operationalization of the new/expanded services that you have described above. Include the expected completion date for each milestone.
- List the activities and milestones chronologically to show what can be achieved by three months, six months, nine months and one year.
- If you already have a more detailed project plan this can be attached as an appendix.

Budget

Using the budget template that has been provided by your OH regional representative, provide a detailed budget for the new or expanded IPCT.

Include your detailed budget as an appendix to this template.

- Consider including any costs related to the inclusion of Indigenous Partner organizations
- Consider what costs will be required to coordinate and support the implementation
- If Non-Insured costs have not been built into the budget ensure that you request this funding and/or work with the Alliance to advocate for it.
- Consider interpretation costs

Risks and Mitigation

In the chart below, list any anticipated risks related to ability to implement the new or expanded IPCT along with steps you will take to mitigate the risk.

Consider including any of the following relevant risks.

- HHR risk and potential difficulty in filling roles.
- On-boarding of new staff → discuss all HR procedures currently in place
- Large expectations and short time frame → discuss participating in Community of Practice to learn from other sites and share innovation

Conclusion and Appendixes

Include all appendices in the table provided.

Your full budget should be included as an appendix

Target Number of Patients Served

Ontario Health will work with you to set a target number of patients who will be served by the new/expanded team. For all sites with a SAMI this should be applied to the MD/NP targets.

Note: You will be expected to count the number of people that are registered to a MD or NP and the number of people who are provided ICPT services that have a provider elsewhere. The Alliance is working on EMR instructions to ensure proper data entry which will enable easy reporting.

Appendix A

The Better Health Innovation (BHI) was implemented in 2011/2012 at Merrickville District Community Health Centre (now part of Rideau Community Health Services). BHI was an innovative response to an urgent crisis in the community, when thousands of patients with complex health and social care needs were unexpectedly orphaned following the retirement of their primary care provider and the subsequent death of the provider to whom these patients were transferred. This promising practice was an enormous success and resulted in registering 500 of the most complex patients to primary care. The BHI was a collaborative community response that included numerous partner organizations such as: the Local Health Integration Network, Home and Community Care (formerly Community Care Access Centre), the Township and the district hospital. Data sharing agreements were created amongst partner groups and data were used to inform decisions and drive improvements to the initiative.

The primary goal of the initiative was ensuring efficient and effective attachment to high quality, team-based primary care by:

- identifying, and developing plans for addressing, the complexity of health and social care needs experienced by prospective patients;
- ensuring medical records and histories were part of newly completed charts;
- co-creating goals of care to support effective attachment and high-quality care that is aligned with patients' needs and values and minimizes unnecessary burden on the primary care provider to whose roster they would be added

The initiative advanced a model of group intake conducted in 'waves' by an interprofessional team, which included social work, nurse practitioner (clinical lead), registered practical nurse, pharmacist, part time consulting physician, and administrative personnel. Each wave, happened over a 6-week period, during which time group/wave of 8-10 patients underwent a full assessment of health and social care needs, medication reconciliation, and chart creation in advance of formal attachment.

Prospective patients participated in 3 group visits and 2 individual visits with specific providers depending on identified care needs, and as part of this process they also received psycho-educational sessions in a number of different areas, such as chronic disease self-management, medication management, goal setting, and preventative screening education. As patients were engaged in visits, the team worked behind the scenes to gather medical histories and records and create updated charts, in

collaboration with partnering agencies, such as the hospital and Home and Community Care. Not all prospective patients were receptive to this process; however, an unanticipated positive consequence of the group and individual sessions was that patients felt that they had built new relationships and skills and reported feeling seen, heard, valued and worthy.

More information is available upon request. Please contact Jennifer Rayner at jennifer.rayner@allianceon.org for a copy of the report.