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Policy Instrument

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Deputy Minister
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INTERDISCIPLINARY TEAM-BASED CARE

POLICY OBJECTIVE

Effective health care delivery requires interprofessional collaboration and coordination to place the patient at the center of care. Interdisciplinary teams of health care providers and support staff will be established across British Columbia as an essential attribute of the Integrated Primary and Community Health Care System to optimize access, service and care.

Interdisciplinary team-based care will be supported by structures and processes that enable inquiry and collaboration across all disciplines, promote engaging the patient voice, and ensure cultural safety and acceptability in care delivery. Interdisciplinary teams will provide person-centred care, improve information and understanding, ensure informed decision making, and enhance understanding of self-management strategies for individuals, families and caregivers. The principles of dignity, respect, information sharing, participation and collaboration will be applied by all health care providers within the interdisciplinary team.

Interdisciplinary teams will meet the care needs of both individuals across the life span (i.e. staying healthy, getting better, coping with illness and disability, and end of life) and the patient population (i.e. by providing access to quality health care services at sustainable per capita costs and as close to home as feasible).

Teams will be designed using a population-data-informed and evidence-based approach. They will be sustained by applying quality improvement and practice related strategies to optimize collective competence and overall team productivity.

Expected Impact on Health Outcomes and Service Attributes

It is expected establishing interdisciplinary teams will achieve meaningful health outcomes (effectiveness) and a quality service experience linked to key services attributes (accessibility, appropriateness, acceptability, safety, equity and efficiency). Measurable expected impacts include:

1. *Accessibility:* An increased proportion of the community population has timely access to appointments in various health service areas.
2. *Acceptability:* Patients' experience of care and service delivery meets the needs of patients, families and caregivers. Patients are informed decision makers in their care journey to achieve their health goals.

3. *Safety:* Improved continuity of patient health information and care management.
4. *Efficiency:* Increased care delivery by generalist health care providers working to their optimized scope of practice to meet health care needs from prevention to end of life.

DEFINITIONS

See glossary for common definitions

Competency: A principle of professional practice identifying the ability of a health care provider to administer safe and reliable care on a consistent basis.

Competencies: The minimal competency requirements for health care providers in an interdisciplinary team, which are common to the overall health care system, as set out by regulatory bodies, legislation and as articulated in job descriptions.

Interdisciplinary team: A group of health care providers who work together in a coordinated and integrated manner with patients and populations to achieve health care goals. Effective interdisciplinary teams display collective competency, shared leadership, and active participation of each team member involved in patient care.

Optimized scope of practice: A complimentary approach to team design where the most effective configuration of professional roles is determined by the relative competencies of all health care providers on the team. This means that the scope of each team member is optimized to effectively deliver care for patients; for example, nurse practitioners, nurses, social workers, dieticians or other team members may provide an optimized scope of service for patients while the physician focuses on complex diagnostics or other elements to facilitate the optimal contribution of all health provider team members.[1]

Partners: Organizations and/or entities that have key leadership roles related to the implementation of the BC Patient Medical Home model (i.e. Ministry of Health, Doctors of BC, the General Practice Services Committee, divisions of family practice and family physicians, BC Nurse Practitioner Association and nurse practitioners), primary care networks (i.e. Ministry of Health and health authorities) and Specialized Care Services Teams (i.e. health authorities).

Productivity: A process to evaluate interdisciplinary teams by measuring the physical inputs used (labor, capital and supplies) to achieve a given level of health outcomes in a patient or population. For the purposes of this policy, workforce productivity will be defined as the number of patient encounters per unit of time for a health care provider and/or interdisciplinary team on

[1] *Optimizing Scopes of Practice – New Models of Care for a New Health Care System*. Canadian Academy of Health Sciences (Ottawa, 2014).

the basis of efficiency (cost/patient/encounter), effectiveness (patient outcomes) and access (attachment).

Role enhancement: Clinical practice that acts to optimize scope of practice to maximize the health care provider's use of in-depth knowledge and skills (related to clinical practice, education, research, professional development and leadership) to meet patients' health care needs. [2] [3]

Role enlargement: The process of shifting health service delivery and administrative activities from a task-oriented approach toward integrated care carried out by health care providers and support staff (e.g. medical office assistants) who are able to meet patients multiple and complex needs through care management, managing populations, and planning and implementing appropriate levels of health and social care intervention.[4] [5]

Skill: The ability to use a developed aptitude and knowledge effectively and readily in the execution or performance of a role.[6]

Skill mix: The particular combination of health care providers and support staff that will be used in a specific setting, based on the type and level of their skills and competence, to meet identified patient and population health needs.

Skill management: The organization's ability to optimize the use of its workforce by understanding, developing, and optimizing the scope of health care providers and their skills through approaches such as role enhancement and role enlargement enabling health care providers to develop new skills, abilities, and techniques they did not obtain during previous clinical preparation. [7]

SCOPE

This policy sets out Ministry direction to health service partners (the Partners) to effectively and appropriately plan, use, and evaluate interdisciplinary teams as an essential element of the Integrated Primary and Community Health Care System. Interdisciplinary team composition

[2] Ibid.
[3] Ackerman, MH, Norsen, L., Martin, B., Wiedrich, J., Kitzman, H. Development of a model of advanced practice. American Journal of Critical Care, 1996, 5:68-73.
[4] Dubois, Carl-Ardy and Singh, Debbie. From staff-mix to skill-mix and beyond: toward a systemic approach to health workforce management. Human Resources for Health 2009, 7:87.
[5] Dubois, Carl-Adry and Singh, D and Jiwani, I. The human resource challenge in critical care. In Caring for people wioth chrnonic conditions – a health system perspective. Edited by: Nolte, E., and McKee, M. Open University Press/McGraw-Hill. 2008. p. 259.
[6] Merriam Webster Dictionary. Source: https://www.merriam-webster.com/dictionary/skill
[7] Dubois, Carl-Ardy and Singh, Debbie. From staff-mix to skill-mix and beyond: toward a systemic approach to health workforce management. Human Resources for Health 2009, 7:87.

varies by health service area and may include generalists and/or specialists, along with clinical, administrative support staff and volunteers.

POLICY DIRECTION

The expectation is that the Partners will systematically create and use interdisciplinary teams to provide services to support the integrated model of care, and meet the identified health needs of the population, using the following criteria:

Effective Interdisciplinary Teams

1. Have an identified leader who establishes a clear direction and vision for the team and provides support and leadership. The leader uses the Triple Aim framework to establish and evaluate goals for the team. The leader demonstrates **collaborative leadership**, **ensures role clarity amongst the team** and **ensures the engagement of patients, families and caregivers** to achieve a mutually beneficial partnership between patients and providers. The leader can effectively manage conflict resolution or can access resources to assist with conflict resolution within the team.

2. Use a **core set of principles** that clearly provide direction for the team's service provision. These principles should be visible and consistently portrayed and will include person centredness, cultural safety, self-management, informed decision making, participation and collaboration, efficiency, safety, accessibility and respect.

3. Demonstrate a **team culture and interdisciplinary atmosphere of trust** where contributions of all providers are valued and consensus is fostered with collaborative leadership.

4. Ensure the **patient voice, choice and representation** forms a foundation for a mutually beneficial culture of person centeredness that is evident and integrated into team design, behaviours, care, and service delivery. Team members should be supported to demonstrate values, attitudes and behaviours that make patients true partners in the process of making care decisions. This will require creating opportunities for balancing the needs and expectations of the patients and families with the needs of the health care providers to complete their work.

5. Ensure **appropriate care processes and management infrastructures** are in place to uphold the vision and principles of the service (e.g. referral criteria, communications infrastructure).

6. Provide **person-centred relationship-based care** that includes the active participation of the individual, family and caregivers, in collaborative decision making, care planning and service delivery through their words and actions.

7. Provide **quality person-centred service with documented outcomes** and use feedback to improve the quality of care.

8. Use **communication strategies that promote effective team functioning** through intra-team communication, collaborative decision making, and effective team processes.

9. Ensure the **appropriate use of practitioners and support staff working to an optimal scope** to meet the needs of the patient population being served. The team provides staffing informed by population data and evidence to integrate an appropriate and optimal mix of knowledge, skills, and competencies to meet the needs of the population and enhance team functioning.

10. Facilitate **recruitment of staff** that demonstrates interdisciplinary competencies including team functioning, collaborative leadership, conflict resolution, communication, and sufficient professional knowledge and experience.

11. Promote **role interdependence while respecting individual and overlapping scopes**, roles, and individual autonomy.

12. Facilitate **personal development** through appropriate training, recognition, and opportunities for development.

Team Design

13. **Collaborative planning processes** use data and evidence to determine the population health needs with key internal and, where possible, external partners (e.g. patients, divisions of family practice, staff, contracted service providers, local health societies, non-governmental organizations, denominational health care providers, and community members) appropriate for program and service settings.

14. Planning processes include **analysis of population health data** derived from traditional ministry and health authority sources (e.g. chronic disease registries, Discharge Abstract Data, health system matrix), panel/caseload assessments, community profiles and/or other resources. Data will be validated through consultations with stakeholders and service partners including, but not limited to patients, care providers, community leaders and health care partners such as contracted providers, non-profit health agencies, and denominational agencies.

15. Use validated population health data to **determine the optimal mix of interdisciplinary team members** required to address the population needs and to achieve the specific service attributes of the health service area. The team optimization process will consider the appropriate balance of preventative and therapeutic care services in addition to analysis of specialized population care requirements (i.e. core tasks), review of current job descriptions, scopes of practice and/or competency profiles, and alignment with health authority and/or Ministry of Health care guidelines and standards.

16. Ensure the desired **skill mix of the interdisciplinary team** considers the needs of the population and the full spectrum of available generalist and specialized health care providers and support staff, working at an optimized scope of practice. Ensures available health care providers are working to an optimal scope of practice before exploring the need to increase capacity through net new providers. Flexible and innovative approaches should be considered for rural and remote communities where the number and mix of providers are limited.

17. Develop **strategies to mitigate constraints**, such as the availability of health care providers, including innovative approaches to recruitment and retention, potential enhancement of scope or skills of current providers, flexible models of service delivery (e.g. practice generalism, job sharing, joint service delivery between health authorities[8], virtual care, over-staffing) and effective use of available providers (e.g. nurse practitioners, traditional healers, staff of non-government organizations) to meet population needs. Role enhancement, enhanced scope, and use of existing providers (i.e. remote certified nurses, community paramedics and first responders) are critical in remote communities.

Optimizing Team Functioning

18. Ensure interdisciplinary teams are supported by **effective on-site clinical leadership** that promotes collaborative trust-based practice, facilitates team problem solving, clarifies team members' roles, ensures effective team communications, applies process improvement to optimize team function, and ensures shared accountability for patient care and professional performance.

19. Employ effective **change management strategies** to support the optimization of the interdisciplinary team. This includes supporting the transition to team-based approaches, using coaching and mentoring approaches to support team members, and establishing a culture of **collective competency** through improved cooperation, coordination, and

[8] For example, in rural communities interdisciplinary teams may be created with health care providers from the regional health authority and First Nations Health Authority.

communication while focusing on the shared goal of achieving optimal outcomes for all patients.

20. Ensure **interdisciplinary team care management** and collaborative decision-making processes are consistent and equitable, including but not limited to clear protocols for case conferencing and effective transitions of care within and between networked services, and mechanisms for effective communication (e.g. huddles, case meetings, shared charting/EMR) among providers.

21. **Use digital technology**, where possible, to optimize networking within and between interdisciplinary teams and team members to ensure timely access to care, robust communication, and effective clinical decision making. Digital technology includes, but is not limited to, virtual care which will be embedded into day-to-day operations to link clinicians and care providers with patients to improve effectiveness in care delivery.

Interdisciplinary Team Sustainability

22. Use **continuous quality improvement** and other effective management approaches to optimize team performance and strengthen integration services through process improvement (e.g. patient journey mapping, standing orders/protocols), service harmonization, seamless communication, collaboration within and between teams, and a focus on achieving Triple Aim objectives.[9]

23. Encourage **individuals, families and caregivers** to provide informal and formal feedback that is embedded as a critical component of the interdisciplinary team's cycle of continuous quality improvement.

24. Commit to **ongoing skill management** to enable interdisciplinary team members to practice at an optimal professional scope of practice, and to access opportunities for continuing professional development that maintains or enhances an appropriate balance of unique and shared clinical skills required to ensure safe, competent, cost-effective, and ethical care.

25. Provide opportunities for **interdisciplinary education** that enable teams to receive information and training together, rather than in separate disciplines, in areas such as new guidelines, cultural safety and humility, clinical best practices, and information on the functioning of the health system to support system integration activities.

[9] The term "**Triple Aim**" refers to the simultaneous pursuit of improving the patient and provider experience of care, improving the health of populations, and reducing the per capita cost of health care.

26. **Determine interdisciplinary team productivity** by undertaking comprehensive patient and population profile assessments, in addition to continuous improvement strategies, to determine the target interdisciplinary team case load or panel size. It is recognized that team composition will vary due to population needs, team practice models, health human resource available, and geography.

27. **Optimize interdisciplinary team productivity** by employing process improvement tools (e.g. LEAN) and innovative approaches including, but not limited to, active care management, delegation of clinical tasks, same-day scheduling to enable 'real time' referrals (e.g. advanced access methods), group appointments, on-site Specialist shared care, extended hours of operation, and digitally-enabled care such virtual care and email to enhance team and patient communication.

LINKAGES

Organizational Capacity

Data Analytics and Reporting

Data collection and submission should be comprehensive, accurate, and timely to support the value proposition of interdisciplinary team-based care, ensure an adequate and thorough understanding of population and patient needs and baseline service levels, and to plan for and assess improvements over time.

Data and analysis will be provided by the Ministry of Health to support service delivery planning at both the Local Health Area and Community Health Service Area levels. Collaboration and dialogue on these products can be used to inform strategic planning, gap analysis and subsequent roll-out in a range of environments. These tools can also be used to understand the baseline for performance.

Integrated analytics will support performance monitoring, reporting and evaluation in line with the strategy for health system performance management.

MONITORING AND EVALUATION

The Integrated Primary and Community Care System general policy direction acts as an enabling policy for the entire suite of policies representing Ministry Strategic Initiatives. Enabling policies lay the foundation for overall health system transformation to take place, and help to address structural and systemic issues and enhance the effectiveness, reach and impact of general and supportive policy directions.

REVIEW AND QUALITY IMPROVEMENT

1. The policy will be refreshed as needed and reviewed three years from the <insert date of implementation> and following completion of the periodic evaluation.
2. The policy may also be reviewed as determined through consultation between Ministry and external stakeholders.

3. As part of the larger Primary and Community Care Strategic Initiative the performance of this policy contributes to the overall success of the strategy and Review and Quality Improvement will take into account all policies under the strategy.