

# IntegratedCare4People

Enhancing primary healthcare delivery in  
the inner-city community in Toronto,  
Canada

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## LEADING PRACTICES

MAY 2016

*Practice case profile*

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## A. ABSTRACT

The St. Michael's Hospital Academic Family Health Team (SMHAFHT) is a large, primary care teaching clinic, affiliated with the University of Toronto, and nestled within the downtown core of Toronto. The Family Health Team provides services to the inner-city community of Toronto through 6 clinical sites located conveniently in these neighbourhoods. We serve the poorest communities in Toronto - people who are significantly impacted by many social determinants of health that negatively affect the quality of one's life, such as poverty, inadequate housing and inequitable access to services.

In identifying the significant impact that social determinants of health have on our community, and in consideration of the research which supports the importance of interprofessional (IP) care and education, our department undertook a visioning and planning process to evolve and 're-purpose' the way we deliver care, how we interact with our patients/community and how we train our learners. Our approach was to first consider what we would want to see as optimal primary care in the future. With this in mind, our team consulted broadly with patients, local community agencies, our health providers and administrative staff as well as our academic partners and funders. Top priorities included:

- improving access to health care services and expanding the types of services available,
- focusing on a stronger team-based model of care with health providers working to full scopes and skill sets,
- articulating a strategy to address social determinants of health and
- developing an innovative way to train our health professional learners through interprofessional education (IPE) and through the modelling of collaborative behaviour within the team.

Unique partnerships with academic institutions and health agencies not typically involved in funded family medicine models have enabled this model. Dental care, psychological treatment and chiropractic care are healthcare services now fully integrated into our department to deliver care without economic burden or barrier to our community. Integration of an income security health promoters, a new legal aid clinic (Health Justice program), a Reach-out-and-Read childhood literacy program and a Frail Seniors' Home Visiting program has helped to address the multiple issues our inner city patients face in their day-to-day lives. The unique mental health service, with psychiatry, addictions counselling, social work and psychology collaborating on service delivery, has significantly improved focused access to mental health care for the right patient with the right provider at the right time.

Our model of care is unique as it incorporates patient/family/community-centered values; IP collaboration; embedded IPE/training of learners; use of advanced communication technology;

and accessible evidence-based care that is supported by ongoing evaluation and research. With the delivery of integrative healthcare services we have experienced improved coordination of care, enhanced patient outcomes and satisfaction, improved quality of work life for our team, and patient/family/community empowerment in self-help strategies.

As a teaching clinic affiliated with several academic training programs (over 300 learners from 11 different professions trained annually), we have embraced IPE, an innovative approach to training health professional learners to enable the attainment of collaborative competency prior to their graduation. As identified by the WHO in 2010, this type of educational approach is essential to ensuring that all health professionals will be competent to practice on health teams which has demonstrated improved patient outcomes, safety and satisfaction, as well as improved provider satisfaction, continuity of care and reduced health care costs.

The sustained impact of our IPC innovation is that, for over the past 10 years, patients, families and the community now have access to a well-functioning and responsive team delivering care, as well as additional health and social care services that they would not be likely able to access otherwise. Longstanding partnerships have contributed to the delivery of these services without economic burden and help to underwrite the longevity of our model. The commitments (financial and human resources) by the hospital and our affiliated organizations continue to enable sustainability. We have been considered as a model for others – locally and nationally, exemplified by being identified as a ‘best practice’ by the Ministry of Health and Long Term Care in Ontario (2007), the Canadian Government Health Care Innovation Working Group (2012) and by the invitation to assist in the design and development of the first Canadian academic Centre of Integrative Medicine at the University of Toronto, enabling transferability of our model.

## B. DESCRIPTION OF THE PRACTICE

### Context and problem description

As in many inner city contexts, the population living in Toronto's Regent Park and Moss Park neighbourhoods struggle with poverty, inadequate housing, low levels of education and literacy, social isolation, single parenthood, language barriers and unemployment. These social determinants of health negatively impact their quality of life and their health status and there is a high prevalence of mental illness, chronic pain, chronic disease and complex co-morbidities, HIV/AIDS and addictions<sup>1</sup>, as well as an increasing burden of chronic disease conditions. People in these neighbourhoods generally lack strong social support systems and there is an overrepresentation of vulnerable population groups compared to the rest of Toronto, with more elderly people, more single parent families and significant numbers of recent immigrants (see graph).

Table 1. Sociodemographic data from Toronto Health Profiles for Moss Park and Regent Park Communities (Adapted from Ref.<sup>2</sup> below).

Census variables	Toronto	Moss/Regent Park areas
% Low-income family	19.4	48.7 / 63.4
% Low-income individual	22.5	56.9 / 64.8
Average household income	69,19 <sup>3</sup>	31,246 / 22,496
Unemployment rate (%)	7.0	12.5 / 22.7
% Age 65 y + and alone	26.6	59.5 / 46.4
% of Lone parent families	19.7	32.5 / 48.2
% Recent immigrants (b5 y)	11.4	47.3 / 28.8

As in many marginalized and underserved communities, thousands of people were unattached to a family physician and unable to access primary care services. There was limited availability of various health care services needed, a lack of access to primary social and health care services and many faced economic barriers to accessing treatment. The population sought care in costly emergency departments and walk-in clinics where there was no continuity of care. Services were delivered by loosely organized teams and on paper charts,

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<sup>1</sup> Wasylenski D. Inner city health. CMAJ 2001;164:21(4-5).

<sup>2</sup> Toronto Health Profiles [homepage on the internet]. Toronto: community health profiles partnership. Sociodemographic data. Available from: [www.torontohealthprofiles.ca/](http://www.torontohealthprofiles.ca/)

<sup>3</sup> The unequal city 2015: Income and health inequities in Toronto. Available from: <http://www1.toronto.ca/wps/portal/contentonly?vgnextoid=d9c1756d5a3ac410VgnVCM10000071d60f89RCRD>. Accessed on Sep 30-15.

which limited collaboration and continuity of care. Health workers had low levels of satisfaction with their work-life balance.

## Key milestones

The St. Michael's Hospital in Toronto has had a Department of Family and Community Medicine (DFCM) for several decades. The start of a health restructuring process by the government of Ontario in the early years 2000, paired with pressure from the community advisory panels, prompted the development of an Academic Family Health team within the DFCM. Based on an extensive and participatory evaluation, the primary care program took the opportunity to start an extensive remodelling to better address the needs of the local communities. The practice was further developed in an iterative process, where opportunities were taken on to further expand and improve the service delivery package and processes and where changes were made through broad consultation and input from all stakeholders. The key drivers for change were responsiveness to patient and community needs, and adaptation to / incorporation of new evidence. Today, the Academic Family Health Team is a large, primary care teaching clinic with 6 clinical sites located throughout the inner city of Toronto.

*Table 2. Milestones*

2000	Health restructuring in Ontario leads to broad consultation and a remodelling of the health model and the development of the Academic Family Health team in the Department of Family and Community Medicine at the St. Michael's hospital
2004	The package of care is further expanded to include chiropractic services
2006	Recognition by the Ministry of Health and Long Term Care, Ontario, as a Best Practice Model
2009	The package of care is further expanded to include clinical psychology and dental services. Nurse practitioners are integrated in the department
2010	An extra clinical site is opened and the e-record system "one patient one chart" is introduced
2012	An income security health promoter is recruited Start of the frail elderly seniors home visiting program
2012	Recognition of the practice by the Council of the Federation, Health Care Innovation Working Group, government of Canada

2013	Establishment of the Social Determinants of Health Committee
2014	Opening of the legal aid clinic
2015	Opening of a new clinical site Start-up of the reach-out-and-read (ROAR) program Local Practice-based Research Network

## Health service delivery transformations

### Selecting services

Through the introduction of the Academic Family Health team, the existing care model was gradually reformed into a comprehensive program, broadening available services to include social care services in addition to core health care services. Based on the utilization patterns by the population, complementary health services such as chiropractic services and acupuncture have been added to the basic package of services. In response to the high burden of disease related to life-style related health conditions, increased emphasis is placed on health promotion and protection and disease management. And in response to the particular prevalence of disease and disorder in the population, several specialist programs were introduced including a large HIV/AIDS program and specialty programs for individuals with developmental delay, the frail elderly and the LGBT community. The team is also extensively involved in outreach programs and alliances, such as youth shelters, men's and women's shelters, AIDS hospice care, among others.

*Box 1. Which services became available through the practice?*

There has been a considerable increase in the variety and type of services patients are able to access with universal health care coverage (without economic barriers). People living in our roster catchment area (geographically rostered) are now able to receive coordinated and comprehensive care by an interdisciplinary, highly functioning health care team. They are now able to access health care services not traditionally found or funded within public funded health care in Canada. All of these programs are highly utilized with demand currently outstripping supply. These unique services include:

- Collaborative mental health care (by an integrated team of psychologists, social workers, addiction counsellors and psychiatrist)

- Chiropractic care (an integrated musculoskeletal health management program with chiropractic, physiotherapy, chiropody, family medicine, nurse practitioners). As an example of utilization and demand for care, over 300 patient visit appointments are available each week for chiropractic care (6 days per week) and these are fully booked with a current wait list of approximately 180 patients waiting for an initial visit.
- Dental services for people meeting the poverty criteria
- Income security services by embedded income security health promoters
- Health justice services by collaborative partnership with department health providers and legal aid
- Home visiting program for Frail Elderly (by an interdisciplinary team of physicians, nurses, nurse practitioners, social workers, dietitians and pharmacists). Over 830 home visits were provided in fiscal 2014-2015. 20% of the department's practitioners provide home visits.
- 24-hour call-in service available for all patients.
- And others

## Designing care

The design of care is based on evidence, supported by a long and proactive research tradition and on an explicit aim of advancing systems of care for disadvantaged patients and of being responsive to patient needs. The SMHAFHT has a strong commitment to inclusion with respect to operational processes, frequently seeking input from patients, the community, staff and department providers, to design innovation in the care delivery process. Barriers, including economic barriers to accessing care, are mitigated by innovative financing approaches and by inserting clinical sites within the communities and active outreach programs. A health determinants approach and a strong patient- and community centred focus is inherent to all care.

Continuity of care has been improved in several ways: Hospital-to-home care continuity is guaranteed by a full time registered nurse providing a follow-up intervention for all patients discharged from hospital within 72 hours. All patients are booked to come into the clinic within 7 days for post-surgical follow up by their primary health care team. The Community Care Assess Centre staff are embedded into the clinics to ensure seamless transition of care from hospital to home or home to long-term care. Formalized coordinated care plans and shared

programs/services occur with targeted patient populations (children's services, geriatric services, diabetes, mental health and addictions, long term care, etc).

## Organizing providers

The SMHAFHT has developed a very cohesive department workforce through a methodological approach to advancing interprofessional team development. There are frequent opportunities for site-specific team meetings (weekly or biweekly), department-wide meetings (quarterly and semi-annually) as well as additional opportunities for department staff to interact with each other. Coordination of health workforce management is facilitated by the clinical leader managers, two individuals who have the responsibility of overseeing three clinics each and then meeting on a frequent basis to keep each other informed of different site issues and developments. A weekly electronic newsletter sent to all department staff, provides frequent information about the 'goings on' in the department and keeps people informed of our activities. Department staff have reported on the improved enjoyment of their work life when they feel like they work on a well-functioning team.

*Box 2. An example of how team "huddles" are organized.*

As an example at the Sumac Health Centre site, the entire health team has protected time booked into their clinical day in the morning before clinic starts and at midday. During this protected time, the team participates in a team 'huddle' where they discuss what the day's schedule is like, any issues that are expected or may arise in the day, and clinical case scenarios. This has resulted in the site providers and staff feeling very supported by other team members and a resulting high level of team cohesion. Team huddles have been shown to improve team functioning and efficiency.<sup>4</sup>

The SMHAFHT purposefully plans opportunities to enhance interprofessional team development by having representative inclusions on all department committees and working groups, by offering faculty development programs on interprofessional collaboration and by offering numerous interprofessional education (IPE) sessions on an ongoing basis which facilitates team-teaching and increased collaboration. An Education Committee oversees the numerous interprofessional education programming offered to students placed in the department and for department providers and staff. Annually, the Committee undertakes a

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<sup>4</sup> Institute for Healthcare Improvement. Meeting tools: huddles. Available at: <http://www.ihl.org/IHI/Topics/Improvement/ImprovementMethods/Tools/Huddles.htm>. Accessed Dec 18, 2015.

needs assessment to determine needs around continuing education of all clinical and administrative staff. Biweekly, monthly and quarterly education sessions for clinicians and staff are provided, all taught interprofessionally and to an interprofessional audience. Topics are selected that are relevant to the broadest range of providers in the department and have included of interprofessional conflict management, interprofessional teaching and care coordination. Through evaluation of these educational programs we have achieved enhanced understanding about each other's skills and scopes, enrichment about the characteristics of highly functioning teams, enhanced team work as well as improved care delivery through non-hierarchical team-based delivery within a collaborative leadership model of care.

*Box 3. How was the role of pharmacists expanded?*

The department has 4 primary care pharmacists shared across the 6 clinical programs. The role of these pharmacists is to help with medication management and oversight. They perform medication reviews collaboratively with patients and practitioners to ensure that the patient is being managed safely and efficiently. The pharmacists also offer consulting regarding prescribing and provide educational programs on new and emerging evidence around pharmaceutical management. In the weekly DFMC electronic newsletter that goes out to the entire department, the pharmacists write frequent columns providing updates on prescribing practices, including medication reconciliation. This is a very highly valued and utilized service in the department by both carers and users.<sup>5</sup>

In order to advance interprofessional team work in a large department with staff spread over 6 clinical locations, and in addition to existing opportunities to interact (co-location of health team members, team meetings for example), the introduction of an electronic health record (EHR) further supports collaboration and communication within the health care team. "One patient, one chart" enabled all health providers to have easy access to all others clinical notes and for staff to easily access any component of the patient's chart through one electronic mechanism. The messaging system within the EHR also expedited communication by having the ability to send a message tagged to a patient chart to another provider, but also having the ability to send an urgent message when needed, interrupting the provider's (to whom the message is addressed) ability to use the system until the message is responded to. An additional innovation in this system was the creation of a special custom toolbar to assist with

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<sup>5</sup> For more information, please review the video on medication reconciliation through this link: <https://www.facebook.com/video.php?v=1053266461371588&set=vb.116986731666237&type=3&theater>

organizing patient preventative care measures. The toolbar contains current information with respect to health promotion and prevention, such as dates of last and next complete physical examination, flu shot, fecal occult blood test (FOBT), mammogram, pap smear, colonoscopy and bone mineral density (BMD). When the preventative care measure is overdue, that section of the toolbar turns red. This serves as a reminder for the practitioner and the patient that it is time to conduct the tests. This supports the Ontario Ministry of Health and Long Term Care preventative health strategy in disease prevention. Taking an action on the tool bar (entering dates of completed tests, for example) automatically generates a time/date stamped clinical note in the chart. With the introduction of this preventative toolbar (inserted below), the rates of compliance with these health tests has significantly improved.

Last CPX: May 12, 2011	Last Flu Shot: Nov 30, 2011	Last FOBT: August 20, 2011	Last Mammo: no data	Last Pap: Aug 1, 2012	Last BMD: no data	Last Colonoscopy: no data
Next CPX: May 12, 2012	Next Flu Shot: Nov 30, 2012	Next FOBT: Aug 20, 2013	Next Mammo:	Next Pap: Jul 1, 2020	Next BMD:	Next Colonoscopy:

Efforts have been done to improve access to services, by reviewing the booking system. The Advanced Access (AA) study implemented a change in how the department books patient appointments, reducing pre-booked appointments with family physicians and NPs to only 50% of the available day appointments. The other 50% of appointments are reserved for acute/urgent access to facilitate patients being able to access their primary care provider within in 24 to 48 hours. In the AA study, despite only pre-booking 50% of one's clinic day in advance, all days are fully booked and patient timely access to care has significantly improved (96% reported they could access their physician within 24 to 48 hours in 2014). Since the start of the practice, the number of clinical settings has increased from four to six clinics and the availability of providers has been increased through extended clinical hours, 24 hour telephone line, and the ability to accommodate large numbers of new patients (previously unattached to a family physician).

## Managing services

Numerous interprofessional committees plan and oversee department operations and processes. Program management models are implemented to manage services for specific diseases (see box below).

In order to be able to provide the significantly expanded menu of services, the SMHAFHT developed collaborative, funding partnerships with several organizations to support these services. As a teaching clinic, funding for the education of health professional learners is underwritten by the University of Toronto (with multiple health professional training programs), the Canadian Memorial Chiropractic College, and Ryerson University, to support student placements (medicine, chiropractic, psychology and other learners) in the department. Much

of the clinical care delivery is provided by learners under direct supervision by clinical faculty, thereby mitigating the cost of care for patients. The department also receives a significant amount of funding through quality improvement initiatives, innovation funding and research grants. Research funding has been used to expand services, for example through a large research project in 2004 chiropractic services were included in the hospital, thus providing access to complementary therapies.

*Box 4. The example of the diabetes programme model.*

Implementation of a program management model to address diabetes for example, was created with the development of a diabetes team, hiring of staff with expertise in the management of diabetes and development of group class sessions where a larger number of patients would have access to early lifestyle intervention. A long-term funding mechanism through the public payer system has resulted in long-term sustainability of the diabetes program. Building on the success of this program the department expanded the number of these types of programs offered over a 3 to 5 year period in early 2010. Currently patients can access a number of programs which are delivered by an interdisciplinary designated team in collaboration with patients who are often involved as co-teachers in these programs. Group sessions are now offered for diabetes management, COPD, smoking cessation, pre-natal, breast feeding group, mindful meditation program, life after trauma groups, healthy eating (Craving Change), seniors friendly program, etc. These programs all require an embedded evaluation component so that participants may provide the opportunity to provide feedback and input into ongoing program development.

## **Improving performance**

Improving quality and performance is an inherent principle in the management approach of the practice. The focus is on positive improvement and learning from experiences, rather than taking a punitive approach when issues arise. In addition to the commitment to continuing education of all clinical and administrative staff, mentioned above, the department actively undertakes quality improvement (QI) projects on an ongoing basis and is committed to continuous evaluation of the services and model of care delivery. Change has been ‘designed’ through these evaluative mechanisms which help us learn how better to meet the needs of those we serve and those who are providing the service. A Quality Improvement Committee oversees all data collection for quality assurance, analysis of data, comparisons and makes

recommendations for programmatic change as needed to achieve or exceed the provincial targets. The committee also oversees all QI projects occurring in the department. One project is the ongoing collection of patient experience data. The SMHAFHT has a standardized, centralized approach to collecting patient experience information, through two data collections mechanisms: online patient surveys and on-site surveys in the waiting rooms tablet computers. These additional priority indicators for the program focus on utilization, health equity (collected through surveys) and patient experience (timely access to care, availability of needed care, and patient satisfaction with the services, including patients' perceptions of how well the team worked together in the delivery of their care). The patient reported outcome measures (PROMs) are immediately uploaded in the electronic health record (EHR), allowing capturing information from patients specifically related to their experience of care and health equity.<sup>6</sup>

## Engaging and empowering people, families and communities

A strong commitment to responsiveness to patient and community needs, a long-standing tradition of participation of patients, community advisory panels (HIV, Women's Health, Seniors, Homeless), the hospital and department providers in the evaluation and design of the care model and extensive self-assessment processes have been important triggers that drove the development of this practice and remain so today.

To strengthen patient and public health education, an initiative led by Dr. Mike Evans has achieved substantive success worldwide in his innovative 'edutaining' white board videos about various health issues.<sup>7</sup> The department also uses social media technology to communicate with our patients, the community and the public. With a Facebook page and twitter feeds, communication lines are open in both directions between the department and our community.

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<sup>6</sup> Comprehensive information about our experiences in administering a patient experience survey and our Quality Improvement Measurement approach can be found at: <https://www.youtube.com/watch?v=rfrbOrV-g9I> This video describes the implementation of the patient experience survey through email and tablet data collection. Patients are sampled once per year (on the date of their birthday which prompts the automated email delivery system). By March 2016, we expect to have 16,000 patient email addresses collected for this purpose. The video also focuses on how we created the patient experience survey ensuring that it is not overly onerous and it is easy to complete by patients (10-11 closed ended questions and 2 open-ended questions). We also utilized questions from the Commonwealth Survey so that we can compare results to other jurisdictions across Canada, the US and the UK.

<sup>7</sup> To learn more about this successful initiative and to access these videos, please visit: [www.evanshealthlab.com](http://www.evanshealthlab.com).

## Section four: Conditions enabling change

Research conducted early on in the evolution of the practice demonstrated that organizational culture was of pivotal importance in facilitating change. The commitment to core principles of evidence-based care, health equity, patient/family and community centredness, integrated health care and ongoing innovation has been critical to our success. A pledge to ongoing quality improvement and a proactive research agenda to study the impact of the new model of care have been equally important.

SMHAFHT works within existing regulatory frameworks to support care delivery and has strategically used regulatory enhancements for the inclusion of physiotherapy (advanced practice), nurse practitioners (who have a significantly expanded role as a primary contact provider now) and in the approach to pharmaceutical management. Enabling these providers to work to full scope and skills offsets other health service demands, improves patient access, and also improves health worker satisfaction.

*Box 5: An example of the expanded scope of the physiotherapy practice.*

The Advanced Practice Physiotherapist in Arthritis Care practice scope enables the physiotherapist to oversee the management of care related to osteoarthritis (ordering and reading imaging, reviewing medication, coordinating specialist care, etc). In the aging, global population, the burden of musculoskeletal disorders and osteoarthritis is increasing. Being able to utilize changes in regulatory scopes to more effectively and efficiently manage patients with OA is important. We have been able to initiate this type of program recently in our department. As another example, the province has expanded the role of pharmacists who are now able to renew medications for certain prescriptions without the need for the patient to visit the family physician. This improves access for patients and system efficiency.

Reform in Ontario of family physician payment schemes away from a fee-for-service schedule towards a blended capitated model of payment resulted in the opportunity to evaluate the effect of the new payment scheme on the management and prevention of chronic disease [Kiran et al, 2015]. The Family Health Team funding structure based on this reform enabled the provision of a comprehensive set of health care services in a publicly funded, universal health care system. The Family Health Team bundled funding enables the hiring of health professional staff according to the needs of the local community and is determined by the number of rostered patients and the complexity of health issues within the catchment population. For example this bundled funding allows the hiring of nurses, nurse practitioners,

dietitians, physiotherapists, social workers, pharmacists, chiroprodists, etc on a salaried basis rather than a fee-for-service mechanism not affordable by our patient population. The study mentioned above indicated that the shift to capitation payment and the addition of team-based care in Ontario were associated with moderate improvements in processes related to diabetes care. The effects on cancer screening were less clear. These results indicate that, on a broader scale, funding mechanisms in Ontario have an impact on care delivery and outcomes of care.

### Section five: Barriers to change

Throughout the development of the practice, barriers to change were tackled without major limitation to its further development. One challenge faced was the requirement to change our department organizational structure (as a Department of Family and Community Medicine) to the required governance structure outlined by the government for the operation of Family Health Teams. The DFCM did not want to become autonomous from the hospital and a lengthy negotiation period ensued with the end result of a blended governance structure that meets the needs of the government, the hospital and the team.

Current payment systems do restrict what the department is able to do and accomplish as with any complex, publicly funded health system. Unfortunately, some of the services provided in the department are not provided for by universal health coverage (psychology, chiropractic services, dental care). However, these services were enabled by the formal academic affiliation agreements between Ryerson University, the Canadian Memorial Chiropractic College and Toronto Public Health which offer services within the context of teaching clinics to be able to provide care without any economic barrier to patients.

### Section six: Outputs, outcomes and impact

Evaluation of the program outcomes has indicated an improved patient experience of care. Access to a primary care provider has significantly improved with 96% of patients reporting that they were able to get an appointment with their primary care provider within 24-48 hours of need. Results from patient experience surveys have indicated that patients were satisfied with the nature and type of services available and these services are highly utilized (demand outstripping supply).

Results from tracking of health outcomes and quality indicators has revealed that health promotion and preventative care approaches are addressing more patients than ever before and we are generally meeting or exceeding the provincial targets across most of the 9 quality indicators set out by the Ministry of Health and Long Term Care. Improvements continue to be

made here as the department implements quality improvement initiatives to address any deficiencies.

Services are readily available without economic burden to patients. They now have access to types of services that were previously unaffordable to them (dentistry, psychology, chiropractic care etc). By maximizing the scopes and skills of the health care practitioners, appropriately managing different health conditions by providers other than family physicians, the cost of providing care has likely been reduced. The availability of long clinic hours (6 days per week, 5 evenings per week and a 24 hour 'hot-line') has likely also reduced the utilization of the emergency department for our rostered FHT patients. We are currently looking at this type of data to help confirm the improvement in health care costs resulting from our comprehensive health team model of care.

Preserving and improving work-life balance and satisfaction with work life has also been an important focus for the department. Frequent opportunities are provided for staff and practitioners to provide feedback on or input into program development and organizational processes. For the most part, all administrative committees have representation of administrators, staff and interprofessional health carers to ensure that broad perspectives are received and considered. Initial results from research projects undertaken in the department regarding interprofessional team development, team teaching and satisfaction with work life indicated that practitioners were very satisfied with the team-based approach to health care, that they valued and respected others views and that they felt this model of care was helping to improve patient outcomes. The department has endorsed the evolution of the program along the Boon (2004) continuum towards integrative care and continues to evolve in this direction.

Over 300 health professional learners participate in interprofessional education (IPE) programs each year in the department. Over 8 years of IPE program evaluation data has demonstrated that learners are highly satisfied with this educational approach, that they attain the required knowledge disseminated in the modules and that they improve their collaborative practice competency. Students are also highly satisfied with the educational approach. Research amongst interprofessional teachers has demonstrated that their teaching experiences are enhanced when they teach together and they also report that collaborative teaching enhances their clinical team functioning. Teachers report a very high level of satisfaction in teaching within these programs.<sup>8</sup>

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<sup>8</sup> For more information, please refer to attached EDF Study Final Report.

The practice and its model of care has been recognized by the Ontario government provincially and Canadian government federally as a best practice model. It has also been utilized as a model of care for expansion of Family Health Team services in Ontario. In addition, individuals in our department have been invited to several provinces and countries to advise on our model of care. The department is frequently approached for consultation in various areas of work (Refugee health, Global Health, Inner City Health, Models of integrated and patient-centred primary care, etc) and we are actively working with the University of Toronto on the development of their innovative Centre for Integrative Medicine. The department has also been the recipient of awards with respect to the interprofessional education activities (from the University of Toronto and from the Hospital).

## Section seven: The process of leading and managing change

### **Key actors**

The primary responsibility for the development and evolution of the practice is the St. Michael's hospital and the Academic Family Health Team and its providers and community/patient partners. Collaboratively the Board Chair and the DFCM Chief work closely with hospital administrators as well as department staff and providers. The practice benefited from very highly motivated leadership at all levels that has been fully supportive of adopting comprehensive team-based care and also moving towards an integrative health care model. The commitment by hospital and department leadership to empowering individuals in a collaborative leadership model (champions) of management has resulted in enhancing organizational and individual commitment to continued evolution of our team-based health care model [Boon and Kachan, 2008]. Facilitation of enhanced service provision occurred through collaboration with several academic institutions and organizations<sup>9</sup>.

Important factors in driving the process of change has been the identification of “champions” and institutional facilitators to conceive of, advocate for, and bring the programs to fruition. The credibility of these champions and facilitators was key to the acceptance and growth of the program in each setting. The ability to find the ‘right’ practitioners and staff to establish the integrative team was crucial to each program’s ultimate success. The importance of trust (both the trustworthiness of the developing program as well as the trust that developed between the practitioners in the integrative team) was paramount.

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<sup>9</sup> Partners include the University of Toronto, Ryerson University, The Canadian Memorial Chiropractic College, Toronto Public Health, the Community Care Access Centres (CCAC), Toronto Public Library, Regent Park Community Health Centre, Community Support Services (Shelter services - Seaton House, Fife House, Casey, Covenant House), New Visions Toronto Supportive Housing, Centre for Mental Health and Addiction, Focus Mental Health program, Sherbourne Health Centre, ARCH Disability Law Centre, Health Links Coordinated Care Planning, Long-term care facilities (Fudger House, Baycrest, Morrow Park), Good Neighbour’s Club, and so forth.

Moreover, a long tradition of educational and research programs underpinned the program developing and the partnership between the university and the clinical settings allowed for the provision of educational and clinical training opportunities.

## Process of initiating change

The Community advisory panels that were in place, as well as the commitment of leaders at all levels of the hospital and primary care setting pushed for the change of reforming the model of care to a team-based, comprehensive and people-centred health care model. Patients and local community agencies participating on the community advisory panels identified unmet needs within the community and urged the hospital to address these needs. External and internal environmental scans and a needs assessment was undertaken to further identify areas of overlap and gaps in our care model. These processes facilitated active engagement of patient and community actors in program development and provided significant enrichment to the process. Recommendations for change were brought to department leaders and providers before being advanced into the broader hospital strategic planning processes. Identification of gaps in funding needed to support addition of new services occurred and were addressed by innovative partnerships with governmental, non-governmental agencies and academic institutions. An iterative process over the next decade resulted in our current model of service delivery, integrated within our funded health system in Ontario.

## Moving forward

The practice is long-standing and has consistent financial and political support. It continues to evolve based on evaluation results, and on input/feedback from patients/families/community, staff/practitioners, collaborative organizational partners, the hospital and funders. The program has achieved very high quality of health care delivery with a very comprehensive menu of available services and within a sustainable funding mechanism. A focus on achieving the 'quadruple aim' (improving the patient experience; improving the health of populations; improving the per capita cost of health care; and improving health workforce satisfaction with the quality of their work life) will continue.<sup>10</sup>

The team will continue to work towards improving patient experiences with care, improving quality of care, improving care integration and coordination and improving the quality of work-life for department staff, all in the context of fulfilling a truly integrative medicine program.

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<sup>10</sup> Adapted from the Institute for Healthcare Improvement: [www.ihl.org/engage/initiatives/tripleaim/](http://www.ihl.org/engage/initiatives/tripleaim/).

## Takeaway messages and recommendations

- It is imperative that patients/families/communities are listened to and heard so that program development supports their needs and they are actively engaged on an ongoing basis.
- Organizational culture and leadership must embrace innovation and change. The importance of internal champions, finding the 'right' practitioners and staff to establish and work on the team and the importance of trust amongst participants and the program itself.<sup>11</sup>
- Innovative partnerships that enable creative solutions regarding funding and accessible care provision are essential to ensure success and sustainability.
- Ongoing quality improvement is key to monitoring program outcomes and supporting iterative evolution of the care model. Embedded evaluation mechanisms are important features of an academic primary care clinical model (use of Patient Reported Outcome Measures, Patient Satisfaction and Experience surveys, Health Equity questionnaire, etc).
- Approaching care delivery and program development from a Social Determinants of Health lens has helped to facilitate additional services being delivered that are unique in our environment (Income security program, health justice (legal literacy) program, Reach out and Read program, etc).<sup>12</sup>
- Embedding educational programming within the clinical model of care and supporting clinical teachers in faculty development specifically related to interprofessional collaboration and interprofessional education supports improved team-based care.<sup>13</sup>
- Ongoing, active engagement of patients, practitioners and staff regarding program evolution and enhancement is necessary to ensure that your evolving model is responsive to the needs of patients, their families and the local community served.
- Utilization of technology, where available, such as an electronic health record, has facilitated communication amongst the team across the various clinical settings.

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<sup>11</sup> Please refer to the attached articles by Boon and Kachan, 2008, and Kopansky-Giles, et al 2010.

<sup>12</sup> Please refer to the Brief Summary report attached herein

<sup>13</sup> Please refer to the attached EDF Study report