Ministry of Health
Policy Instrument

Type	**Supportive Policy Direction**
Policy Name	**Team-Based Care**

Version	2.1
Policy Name	Team-Based Care
Effective Date	
Division/Branch	Nursing Policy Secretariat, Health Sector Workforce and Beneficiary Services
Ministry Contact	Chief Nurse Executive ADM, Primary Care
Document Number	
Date	27 August 2020

TEAM-BASED CARE

POLICY OBJECTIVE

The following policy aims to set direction for residents of British Columbia to have access to team-based care in primary and community health care settings.

Team-based care is the central model for building a diverse, collaborative, integrated team of health care providers and administrative staff (e.g., physicians, nurses and nurse practitioners, allied health providers, administrative support staff, volunteers, and community agencies) that optimizes team functioning, enhances the experience of care, improves population health, and supports equitable access to sustainable, high quality primary and community care services. It is the foundation of the current transformational Primary and Community Care Strategy in BC.

Current models of care are not meeting the increased demand for timely, high-quality, patient centred care that is cost effective. As a result, the majority of jurisdictions around the world are moving toward a more team-based care approach to care to ensure patients are at the centre of decision making, all providers work to full scope of practice, and share the workload. Team based care also encourages relational care between providers and between providers and patients. These factors support the triple aim- better health outcomes for patients, decrease costs and improved quality for both providers and patients.

Shifting to a team-based model of care within primary and community care provides a more effective response to the increasingly complex primary and community care needs of British Columbians (e.g., those with chronic diseases (including the frail elderly); leverages the collective skill, expertise, and experience of all primary and community care providers; and supports improved access to comprehensive primary care services and continuity of care.

Team-based care requires supportive structures and processes that enable inquiry and collaboration across all disciplines, promote engagement of patient voices[1], and facilitate the delivery of quality care that is culturally humble/ safe and trauma and violence-informed. Interdisciplinary teams provide care that honours the varied perspectives of team members, patients, families, caregivers and communities; improves clarity and transparency of communications; and supports shared decision making and longitudinal care. Interdisciplinary teams also empower patients to use self-management approaches to better manage chronic conditions at home or in the community and adopt health promotion and prevention strategies to encourage healthy behaviours to prevent disease, disability and injury.

[1] BC Ministry of Health. April 2011. Integrated Primary and Community Care Patient and Public Engagement Framework. Refer to: Principles of Engagement, page 8 at: www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/primary-health-care/patients-as-partners-public-engagement-2011.pdf

Team composition is informed by population-data and evidence-informed approaches (e.g., utilizing Gender-Based Analysis Plus (GBA+) Framework); taking into regard the diverse perspectives of patients and providers (including consideration of lived experiences). Teams are optimized and sustained by applying continuous quality improvement and practice-related strategies to optimize collective competence and overall team productivity; aligning provider strengths with patient and community care needs.

Expected Impact on Health Outcomes and Service Attributes

It is expected that the establishment of a team-based model of care for interdisciplinary teams will support the achievement of the Institute for Health Care Improvement's Quadruple Aim, i.e., improving the health of populations, enhancing the experience of care for individuals (and experience of care delivery for providers), and reducing the per capital cost of health care. Measurable expected impacts as per the BC Health Quality Matrix include:

1. *Accessibility:* An increased proportion of the community population has timely access to primary and community health care services in which care is culturally humble, safe and barriers to receiving care are reduced.
2. *Appropriateness:* Care delivery is specific to a person's context.
3. *Respect:* The experience of care and service delivery is responsive to needs of patients, families and caregivers. Patients/ clients are engaged in their care journey using shared decision-making approaches to achieve their health goals.
4. *Safety:* Improved continuity of patient health information and care management. Care delivery is physically, culturally, and psychologically safe, fostering security for those receiving care.
5. *Effectiveness:* An enhanced method of care delivery that is grounded in best practice (i.e., care is known to achieve intended outcomes). Providers realize enhanced professional satisfaction through collaborative practice environment that enables use of their expertise within an optimized scope of practice.
6. *Efficiency:* Increased efficiencies in care delivery by primary care providers working to their optimized scope of practice to respond to the health care needs of patients and populations including all areas of care.[2]
7. *Equity:* Fair distribution of services and benefit according to population needs.

DEFINITIONS

Collaboration: Based on the foundational tenets of respect and trust, collaboration is the joint communicating and decision-making process with the expressed goal of addressing patient wellness and illness needs while respecting the unique qualities and abilities of each member of the health care team. Collaboration requires competence, confidence and a commitment by the team. Elements that are integral to effective collaboration include cooperative endeavour, shared

[2] Areas of care include: optimizing the early years, strengthening health & wellness, returning to health & wellness, living with illness or disability and coping with transition from life.

planning and decision making, contribution of expertise, team approach, shared responsibility, non-hierarchical relationships, and shared power based on knowledge and expertise.[3]

Collective Competence: A team of individually competent practitioners working interdependently, with shared accountability using a collective knowledge base. Collective competence will continue to evolve depending on team composition, capacity, context and circumstances.

Competence: A principle of professional practice identifying the ability of a health care provider to integrate and apply the knowledge, skills and judgment required for safe and appropriate practice.

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.

1. In-Practice Teams (Patient Medical Homes): Providers and support staff work together within a cohesive family practice or health authority primary care clinic. Although team members will likely work in a single location, a provider might work virtually or be shared part-time with another team. Examples include Community Health Centres, NP-Primary Care Clinics, and Patient Medical Homes.

2. Network Teams (Primary Care Networks): Providers and support staff from various family practices, health authority delivered or contracted primary and community care, and public health services and community-based organizations working together as part of a broader community-based team. Team members likely work in different locations. Some providers likely travel to multiple locations in the network and/or work virtually.

Interdisciplinary Team Work: Effective interdisciplinary teams display collective competency, shared responsibility, accountability, leadership, and active participation of each team member involved to achieve coordinated, high-quality care. This in turn generates value-added patient, organizational, and staff outcomes (e.g., staff satisfaction, quality of care, control of costs, well-being and retention).[4]

Optimized Scope of Practice: An approach to team design where the most effective complement 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 maximized to effectively deliver care through service provision that is based on respective strengths/ skills of

[3] Henneman, E.A., Lee, J.L.(1995). Collaboration: A Concept Analysis. *J Adv Nursing*, 21; 103-109.
[4] Xyrichis, A., Ream, E. (2008). Teamwork: A concept analysis. *J Adv Nursing*, 61: 232-241.

team members, for example, the physician or nurse practitioner focuses on complex diagnostics and establishing a longitudinal relationship over time with patients across health care settings. This approach facilitates the maximal contribution of all team members, supports continuity of care, and optimizes health outcomes.[5]

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, Nurses and Nurse Practitioners of British Columbia) and Primary Care Networks.

Scope of Practice: The activities based on professional regulations that a health care provider is educated and authorized by the employer to perform if they have the competence.

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

Team-Based Care: Multiple health care providers from different professional backgrounds work together and with patients/clients, families, caregivers and communities to deliver comprehensive health services across care settings. Effective teamwork is a critical enabler of safe, high quality care and supports a patient's ongoing relationship with their primary care provider (a family physician or nurse practitioner).

SCOPE

This policy sets out Ministry of Health direction to health service partners (the Partners) to effectively and appropriately develop, implement, and evaluate a team-based model of care as the central model for service design in the Primary and Community Health Care System.

POLICY DIRECTION

It is expected that the Partners will systematically design team-based models for primary and community care employing strategies and activities that leverage collaborative planning; develop sustainable support structures; optimize team culture and functioning; and facilitate evaluation and continuous quality improvement to effectively respond to identified patient and population health needs within the Primary and Community Health Care System. The following principles for collaborative team-based care will be reflected in model design, implementation, and evaluation.

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

[6] Merriam Webster Dictionary. Definition of skill. Retrieved from: www.merriam-webster.com/dictionary/skill

PRINCIPLES

The Institute for Healthcare Improvement's Quadruple Aim Framework informed by the Canadian Medical Association - Canadian Nurses Association's *Principles to Guide Health Care Transformation in Canada*[7] provided guidance in establishing the principles. The principles also included extensive consultative input from health system partners including GPSC, BCPSQC and UBC, existing Ministry of Health policy direction related to person-and family-centred health care, and the Gender-Based Analysis (GBA+) Framework.

Longitudinal Relationships	Interdisciplinary teams are designed and operated in a way that recognizes the importance of and supports longitudinal relationships between patients and a primary care provider (FP or NP) leading to improved care experiences and outcomes overall.
Person and Family-Centered Care	The care team should consider the person as a whole beyond the presenting health issue - centering care on the health needs of individuals, their families and communities with the objective of providing high quality care, improving the overall patient experience and engaging them as full and active partners in their care and in the development of team-based service delivery models.
Patient & Community Engagement	Actively engage patients and community stakeholders in the development, implementation and evaluation of the model for team-based care and related infrastructure as applicable to allow for high functioning teams.
Quality Care	Quality services known to achieve positive health outcomes that matter to patients and families are accessible, acceptable, appropriate and safe. Team approaches are embedded in individual care models for chronic conditions, in addition to tailored care plans to ensure patients have the right providers and services at the right time and place.
Integrated and Comprehensive Shared Care	Interdisciplinary teams adopt an integrated and comprehensive shared-care model for service delivery, built on a culture of trust, collaboration, and open and transparent communications. There is a shared responsibility by all team members to adopt this model of care whereby health promotion and disease prevention drives all policy and system redesign.
Clearly Defined Roles and Responsibilities	Every team member brings a unique, but intersecting, knowledge base and skillset to the care team. Defined roles and responsibilities help set clear expectations and support optimal use of team member skills and abilities to maximize team effectiveness and quality outcomes and experiences of care (for patients and providers).

[7] Canadian Medical Association – Canadian Nurses Association. July 2011. *Principles to Guide Health Care Transformation in Canada.* Retrieved from: https://cna-aiic.ca/~/media/cna/files/en/guiding_principles_hc_e.pdf

Innovative & Iterative Approaches that Support Quality Improvements	Highly effective teams at all levels continually reflect on team functioning, build in feedback mechanisms to learn from successes and failures to improve performance, and inform the development of innovative care delivery solutions that are responsive to evolving patient care and population health needs.
Value-Based Care	Delivery of a high performing, financially sustainable healthcare delivery system requires optimal use of high performing teams to advance the implementation of evidence-informed approaches and enable the achievement of the Triple Aim.
Health Equity & Improved Access to Care	A health equity lens should be considered when planning team-service delivery with particular consideration to improving access to care for vulnerable and marginalized populations. A particular focus on culturally safe and trauma-informed care should also be prioritized.
Change Leadership	Intentionally introducing TBC in a health care system requires specific attention to change management principles, such as ensuring support from stakeholders, having engaged leadership, implementing small incremental change over time, and providing rapid feedback cycles.

TEAM-BASED CARE: BUILDING, IMPLEMENTATION AND EVALUATION

1) BUILDING: **Planning to Redesign Care and Develop Support Structures**

1.1. Teams are designed and operated in a way that recognizes the importance of **longitudinal relationships between a patient and primary care provider** (general practitioner or nurse practitioner) or other care providers as applicable, leading to improved care experiences and outcomes overall.

1.2. Planning processes include **analysis of population health data** derived from traditional Ministry of Health 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 Partners including, but not limited to patients, care providers, health authority public health staff, community leaders and health care partners such as contracted providers, non-profit health agencies, and denominational agencies.

1.3. Care redesign uses validated population health data to **determine the optimal mix of 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, diagnostic and therapeutic care services in addition to analysis of specialized population care requirements (i.e., core tasks), review of current job and role descriptions, scopes of practice and/or competency profiles, experiences of care providers, and alignment with health authority and/ or Ministry of Health care guidelines and standards and regulatory requirements. The optimal mix of team members is also informed by a GBA+ analysis.

1.4. 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. It ensures that the 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.

1.5. Interdisciplinary teams have **clearly defined roles and responsibilities** that are mapped to care processes/routine workflows to support role clarity, collaborative care, and effective care transitions.

1.6. 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, midwives, community paramedics and first responders) are vital to support service delivery in remote communities.

1.7. Optimize use of **information technologies** including effective use of and linkages between electronic medical records (EMRs) to support data collection for collaborative care planning/ provision (including virtual care), and inform continuous quality improvement.

1.8. Design **physical space** to support accessibility through co-location of team members and enhance efficiencies in work flow and communications, in addition to provision of person-and family-centred care. Where co-location is not possible, ensure infrastructure is established to support virtual care.

[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.

2) IMPLEMENTING: Optimizing Team Culture and Functioning

2.1 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 encourages shared accountability and leadership for supporting inclusive patient care and professional performance.

2.2 Employ effective **change management strategies** to support the optimization of the interdisciplinary team. This includes supporting the transition to team-based approaches, using interdisciplinary team-based training, coaching and mentoring approaches to support team members, and establishing an organizational culture of **collective competency** through improved cooperation, coordination, and communication while focusing on the shared goal of achieving optimal outcomes for all patients. Continuous improvement in team function is prioritized and grounded in a culture of rapid learning and inclusivity.

2.3 Provide opportunities for **interdisciplinary education and networking** that enable teams to receive information and training together, rather than in separate disciplines, in areas such as new guidelines, cultural humility and safety, trauma and violence-informed care, gender based analysis (GBA+), clinical best practices, group/team processes that enable team cohesiveness and effective interprofessional collaboration (e.g., developing trust, shared goal setting and decision making, communication skills, conflict resolution), and information on the functioning of the health system to support system integration activities.

2.4 Provide **technical support** for teams to build capability in areas such as business skills development, panel management, documentation, workflow, quality improvement and change management.

2.5 Ensure **interdisciplinary team care management** and collaborative shared 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 communications plans and other mechanisms for effective communication that are grounded in psychological safety (e.g., huddles, case meetings, shared charting/ EMR, standard orders and protocols) among providers.

2.6 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. Digital technologies should also be utilized when in-person opportunities are not available to support peer-to-peer and provincial networking opportunities and collaboratives.

3) EVALUATING: Performance Measurement to Facilitate Continuous Quality Improvement and Sustainable Teams

3.1 Use **continuous quality improvement,** leveraging evidence-informed quality improvement tools and strategies such as the BC Health Quality Matrix and other effective measurement approaches to strengthen integration services and team functioning 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 Quadruple Aim objectives.

3.2. Encourage **individuals, families and caregivers** to provide informal and formal feedback that is embedded as a critical component of the team's cycle of continuous quality improvement. Ensure that the perspectives of patients experiencing marginalized conditions and vulnerabilities are well considered in continuous quality improvement.

3.3. Commit to **ongoing skill management** to enable 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.

3.4. Determine **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 vulnerability, team practice models, health human resources available, and geography.

3.5 Optimize **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 as 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 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 Service Delivery Area and Community Service Delivery 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. Further population-level data and analytics support is available through Medical Health Officers and public health staff within health authorities.

GBA+ will be applied to analytical processes to ensure that policy outcomes are evidence informed, equitable and meet the needs of the population and patients.

MONITORING AND EVALUATION

The Integrated Primary and Community Health Care System general policy direction acts as an enabling policy for the entire suite of policies representing Ministry of Health strategic initiatives. Enabling policies are foundational 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 the Ministry of Health and external partners.
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.