New Nouveau Brunswick

Operational Guide

for Family Health Teams

Vision

Better health and better care with engaged individuals and communities

— *The Primary Health Care Framework for New Brunswick*

Operational Guide for Family Health Teams

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Abbreviations

ACSC	Ambulatory Care Sensitive Conditions
BMI	Body Mass Index
CCHS	Canadian Community Health Survey
CHNA	Community Health Needs Assessment
CIHI	Canadian Institute of Health Information
CSC	Collaborative Services Committee
DAD	Discharge Abstract Database
DH	Department of Health
EMR	Electronic Medical Record
FHT	Family Health Team
FHTC	Family Health Team Co-ordinator
FTE	Full-time Equivalent
HHR	Health Human Resources
LPN	Licensed Practical Nurse
NBHC	New Brunswick Health Council
NP	Nurse Practitioner
OSC	Operations Services Committee
PHC	Primary Health Care
PHCN	Primary Health Care Network
PHCSC	Primary Health Care Steering Committee
RHA	Regional Health Authority
RN	Registered Nurse
STI	Sexually Transmitted Infection

SECTION 1: Introduction

Purpose

The Government of New Brunswick, in collaboration with the Primary Health Care Steering Committee, has committed to implementing family health teams (FHT) throughout New Brunswick. The Operations Services Committee, reporting to the Primary Health Care Steering Committee, was mandated to review FHT models and guide the implementation of a model of care that:

- is aligned with provincial financial realities.
- meets the specific primary health care (PHC) needs of populations/communities served.
- is patient-centered.
- is integrated with other community health services as required.
- is focused on providing 24/7 coverage.

The Operational Guide for Family Health Teams was developed collaboratively with representation from the New Brunswick professional associations (allied health, medical and nursing), the leadership of the regional health authorities (RHA) and front-line providers. It presents a FHT model adapted to the New Brunswick context, outlines direction for implementation and provides a framework for measuring progress.

Vision

The vision of the *Primary Health Care Framework for New Brunswick,* "better health and better care with engaged individuals and communities", will be achieved through an enhanced integration of existing services and infrastructure and the implementation of patient-centered primary health-care teams, working collaboratively together and with the regional health authorities in a shared responsibility structure to meet the identified health needs of the community.[1]

Our vision is that every person in New Brunswick will be linked to a family physician and have access to a FHT.

Executive Summary

Decisions about how locally driven primary health-care services will be delivered begins with a community health needs assessment (CHNA). This dynamic process is undertaken to identify the strengths and needs of the community and establish wellness and health priorities that improve the health status of the population. CHNAs will be conducted in each of the 33 unique communities identified by the New Brunswick Health Council in its 2011 Primary Health Care Survey. This information will also assist FHTs in addressing health issues and capitalize on identified assets and resources within the community.

By and large, the CHNA process becomes an impetus for assembling a collaborative services committee (CSC). This committee includes representation from local residents; community agencies including schools, nursing homes, and local businesses; other collaborative networks or committees, such as a Community Inclusion Network or Wellness Network; clergy; various government departments; and municipalities. The CSC will collaborate with the RHA to address the needs and benefit from the assets identified in the CHNA by providing input into the services and programs offered, providing a forum to which issues affecting the health of the community may be directed and by serving as a link between the community, Primary Health Care Network and the RHA.

FHTs are locally driven, family health-care delivery organizations that include family physicians, nurse practitioners, nurses and a broad range of other interdisciplinary health-care providers, working collaboratively together to provide comprehensive, accessible, co-ordinated family health-care services to a defined population, which includes patients who do not currently have a primary health-care provider. The fundamental membership of the New Brunswick FHT is comprised of family physicians, nurses, licensed practical nurses and administrative support. The addition of nurse practitioners and allied health professionals such as dieticians, social workers, pharmacists, occupational/physical therapists and others will be determined by the priorities identified in the CHNA.

The following essential elements are requisite for all FHTs:

- ***Improved access***
  Improving access to health-care services will include the provision of an after-hours arrangement, extended hours of service and access to same-day and next-day appointments. FHTs will also add unattached patients to the panels of the physicians and the nurse practitioners from the provincial patient registry, Patient Connect NB. Patients of the FHT can access services through any health-care professional on the team.
- ***Team Composition***
  Ideally, each FHT will have at least three full-time equivalent (FTE) family physicians working in collaboration with registered nurses, nurse practitioners and other allied health professionals. Although the primary health-care providers may not necessarily deliver services in a common location/office space, they will nonetheless work collaboratively to provide comprehensive care to all of the patients on the FHT panel.
- ***Common Electronic Medical Record***
  A common electronic medical record (EMR) will be accessible to the entire team. Unless a common EMR is already in place, FHTs will utilize the provincial EMR system.
- ***Fiscal and Health Human Resources***
  Financial and health human resources (HHR) will be deployed effectively and efficiently to support FHTs. Existing resources from both community- and hospital-based environments will be strategically realigned in addition to targeted new investments.

New resourcing, based on a FHT with three primary health-care providers, will be as follows:

- FHT co-ordinator
- 1.0 FTE registered nurse*
- 1.0 FTE allied health professional
- One-time start-up grant and annual operating grant.

** Licensed practical nurses (LPNs) should be considered where family health team needs are a match for LPN's scope of practice*

FHT Essential Elements Checklist

Improved access

- ☐ *Mandatory after-hours arrangement*
- ☐ *Extended hours of service*
- ☐ *Timely care and access (same day, next day appointments) for patients already attached to a family physician*
- ☐ *Adding unattached patients to the physician's or nurse practitioner's panel*

Team Composition

- ☐ *Physician is a core member of family health team*
- ☐ *Will include nurses* (see page 5)*
- ☐ *May include nurse practitioners*
- ☐ *May include allied health professionals*
- ☐ *Primary care providers will not be required to work in the same office space but must work collaboratively to provide comprehensive care to registered patients*

Panel Size

- ☐ *Panel size for each health care practitioner will be determined based on a per provider basis*
- ☐ *Family physicians and nurse practitioners will add unattached patients from Patient Connect NB to their practice when panel is less than the minimum size determined for their practice*

Common Electronic Medical Record

- ☐ *Common EMR accessible to all health care providers. The provincial EMR will be used unless an EMR is already in place*

The Primary Health Care Network (PHCN) will function as the administrative body for FHTs and enable FHTs in achieving their overall objectives. Each of these networks will be lead by a team comprised of leadership of the RHA, the FHTs and a representative of the CSC. The PHCN will assume responsibility for the planning, implementation and co-ordination of FHTs as follows:

a) Assure the appropriate allocation of fiscal and health human resources to the FHTs, based on the Community Health Needs Analysis and feedback from the FHT.

b) Provide support and guidance to emerging and existing FHTs and facilitate learning,

c) Collaborate with the RHA in responding to community needs and issues.

d) Ensure that health outcomes and accountability measures are in place, and aligned with established provincial guidelines as detailed in the Accountability Framework (see section 5: Accountability and Performance Monitoring).

e) Provide reports to the Department of Health as per established provincial guidelines.

f) Address and resolve issues related to overall FHT expectations, performance and accountability.

An *Accountability Framework for FHTs* was developed to monitor the outcomes of FHTs. The FHTs will report to the PHCN on outcome and accountability measures, presented as a set of operational-level and outcome/system indicators.

Background

Assets and Strengths

PHC in New Brunswick is delivered through an extensive network of services by well-trained, competent and dedicated health-care professionals. Currently, 93 per cent of New Brunswickers have a family physician, which is higher than the Canadian average of 86 per cent.[5] The province also has a rich fabric of vibrant and engaged communities and 71 per cent of the population reports a high sense of belonging to community, compared with a national average of 65 per cent.[5]

These strengths provide a strong platform from which engaged health professionals, individuals and communities can address the province's health challenges through a shared commitment to a sustainable health-care system and a healthier population for generations to come.

The Challenges

Achieving the goal of a high-quality, sustainable health care system also requires the challenges and future pressures to the system be recognized and anticipated. For instance, New Brunswickers are living longer and a large percentage of the population is reaching an age where the demand for health-care services will increase significantly. About 80 per cent of New Brunswickers have at least one chronic condition such as Type 2 diabetes, cardiovascular disease, arthritis, depression, obesity, and cancer.[4] Persons who suffer from chronic disease(s) are more likely to have complex needs and be frequent users of acute care services.

People in general are living more sedentary lifestyles and rates of obesity in our province are 25 per cent, compared to the national rate of 18.3 per cent.[5] Moreover, more New Brunswickers smoke (22 per cent) than their counterparts in the rest of the country (20 per cent).[5] Seven per cent of New Brunswickers live below the poverty line.[3]

Addressing the Needs of New Brunswickers with FHT Models

Patient-centered, community-specific, team-based care provided by primary health-care professionals who feel valued and supported are at the core of New Brunswick's vision for health-care renewal. These attributes will steer the renewal of the primary health-care system so that it reaches beyond the traditional understanding of primary health care and involves the entire community. New Brunswick's primary health-care system of the future will work with all the resources available to provide seamless support and quality health services for individuals and families.

Team-Based Care

A shift to collaborative, interdisciplinary care enables health-care providers to work together effectively and efficiently to provide care that is comprehensive and maximizes scopes of practice. Team-based care thus promotes improved patient and provider satisfaction and health outcomes.[11]

Primary health care teams are locally driven, family health-care delivery organizations that include family physicians, nurse practitioners, nurses* (see page 5), and a broad range of other interdisciplinary health-care providers who are committed to working collaboratively.[8, 9, 10] Studies evaluating the addition of nurses* and allied health professionals have shown that clinical outcomes may be superior to those achieved by 'usual care' arrangements.[17, 18]

Patients who are engaged in their primary health care are more likely to recall information, have the knowledge and confidence to manage their condition(s), report satisfaction with their care, participate in monitoring and prevention, and show improvements in health outcomes.[7, 8, 13] These models of care have been shown to reduce emergency department use, improve access to care, enhance patient satisfaction, and improve patient health and quality of life.[2, 8,9,10]

Evidence supports the importance of developing effective teams of health-care providers for improving the quality of care of patients with chronic conditions. The very best place to support people with chronic disease is through primary health care, with a team of health-care providers who understand the unique needs of patients.[8] This level of care also helps empower people to take control of their own health.

Improving health outcomes requires a systematic approach to co-ordinating health-care interventions across levels (individual, organizational, local and provincial), and evidence demonstrates that co-ordination across care settings and providers is more effective than single or unco-ordinated interventions. It is anticipated that further growth and evolution to team-based models of care will ultimately contribute to improved individual and population health outcomes for New Brunswickers.

SECTION 2: Family Health Teams

Definition

FHTs are locally driven, family health-care delivery organizations that include family physicians, nurse practitioners, nurses and a broad range of other interdisciplinary health-care providers, working together collaboratively to provide comprehensive, accessible, and co-ordinated family health-care services to a defined population, which includes patients who do not currently have a family health-care provider.

Composition

The fundamental membership of each team consists of family physician(s), nurse(s)* (see page 5) and administrative support. The addition of nurse practitioners and allied health professionals such as dieticians, social workers, pharmacists, occupational/physical therapists and others will be determined by the priorities identified through the CHNA.

Objectives

FHTs will provide access to primary health care when and where people need care, from the most appropriate service provider(s). The FHTs achieve this by meeting the following objectives.

FHTs will:

1. Be adapted to the needs of the community. FHTs foster community involvement through the active engagement and participation of local organizations and individual members of the community.
2. Meet the unique needs of patients by providing patient-centered care.
3. Facilitate and provide interdisciplinary and collaborative care within teams.
4. Provide health promotion and disease and injury prevention through early detection/diagnosis, increased prevention efforts and health education.
5. Provide timely and appropriate access with extended hours of care.
6. Improve continuity and comprehensiveness of care by facilitating better health system navigation and care co-ordination, linking patients to other aspects of the health-care system such as acute care, long-term care, public health, mental health and addictions, and community-based programs and services.
7. Use quality care indicators to measure outcomes and improve accountability
8. Use information technology for better health-system integration and patient care by adopting and utilizing the provincial electronic medical record to a maximum of available functionality.

Essential Elements

The following elements are mandatory for all New Brunswick FHTs:

- ***Improved access***
  Improving access to health-care services will include the provision of an after-hours arrangement, extended hours of service and access to same-day and next-day appointments. FHTs will also offer to add unattached patients to the panels of the physicians and the nurse practitioners from Patient Connect NB. Patients of the FHT may access services through any health-care professional of the team.
- ***Team Composition***
  The family physician is the core of the FHT and each FHT will have at least three FTE family physicians working in collaboration with registered nurses, nurse practitioners and other allied health professionals. The results of the community health needs assessment will determine other configurations of physicians, nurse practitioners and nurses* (see page 5) where appropriate. Although the primary health-care providers may not necessarily deliver services in a common location or office space, they will nonetheless work collaboratively to provide comprehensive care to all of the patients on the FHT panel.
- ***Common Electronic Medical Record***
  A common electronic medical record will be accessible to the entire team. Unless a common EMR is already in place, all FHTs will utilize, the provincial electronic medical record (EMR) system.

FHT Essential Elements Checklist

Improved access

- ☐ *Mandatory after-hours arrangement*
- ☐ *Extended hours of service*
- ☐ *Timely care and access (same day, next day appointments) for patients already attached to a family physician*
- ☐ *Adding unattached patients to the physician's or nurse practitioner's panel*

Team Composition

- ☐ *Physician is a core member of family health team*
- ☐ *Will include nurses* (see page 5)*
- ☐ *May include nurse practitioners*
- ☐ *May include allied health professionals*
- ☐ *Primary care providers will not be required to work in the same office space but must work collaboratively to provide comprehensive care to registered patients*

Panel Size

- ☐ *Panel size for each health care practitioner will be determined based on a per provider basis*
- ☐ *Family physicians and nurse practitioners will add unattached patients from Patient Connect NB to their practice when panel is less than the minimum size determined for their practice*

Common Electronic Medical Record

- ☐ *Common EMR accessible to all health care providers. The provincial EMR will be used unless an EMR is already in place*

Improving Access

Co-ordinated 24-hour, seven-day-per-week management of access does not imply that providers are required to be on call 24/7, but provisions must be made for access to services after hours. At a minimum, after-hours access agreements are possible through Tele-Care 811, where patients can be triaged to the appropriate services and/or scheduled for a same-day or next-day appointment with a member of the FHT. Access through extended hours of services means that the FHT is open beyond regular hours of business during specific blocks of time, evenings and weekends, as required by the needs of the patient population.

FHTs will play an important role in improving access by opening the door to the health system wider and staying open longer. FHTs will provide co-ordinated 24-hour, seven-day-per-week management of access to appropriate primary health-care services, thereby decreasing the need for individuals to go to several locations and through multiple systems to access the care they require. FHTs will provide direct access to the most appropriate provider(s), with extended hours and same day/next day access, as required by their communities.

Example One

After-hours and extended hours in a FHT with three physicians and one nurse practitioner.

Office hours staffed by a physician and/or nurse practitioner open on two of the following occasions Monday to Thursday night (from 5 pm to 8 pm) or three hours on a weekend.

Example:
Monday 9 am – 5 pm
Tuesday 9 am – 5 pm
Wednesday 10 am – 8 pm
Thursday 12 pm – 8 pm
Friday 9 am – 12 pm
Saturday 9 am – 12 pm

Tele-care arrangements for after-hours service
(Patients instructed to call 811).
Patients triaged to appropriate service and/or scheduled for a next-day appointment with the FHT.

Example Two

After-hours and extended hours in a FHT with six physicians and two nurse practitioners.

Office hours staffed by a physician and/or nurse practitioner open on three of the following occasions Monday to Thursday night (from 5 pm to 8 pm) or three hours on a weekend.

Example:
Monday 9 am – 5 pm
Tuesday 9 am – 8 pm
Wednesday 9 am – 5 pm
Thursday 9 am – 8 pm
Friday 9 am – 4 pm
Saturday 9 am – 12 pm

Tele-care arrangements for after-hours service
(Patients instructed to call 811).
Patients triaged to appropriate service and/or scheduled for a next-day appointment with the FHT.

Interdisciplinary Collaborative Care by FHTs

All FHTs will operate as collaborative interdisciplinary teams working in person-focused environment. Collaborative care is a patient- or client-centred process in which two or more professions or disciplines interact to share knowledge, expertise and decision making in the interest of improving patient care.[19] In 2010, the World Health Organization defined inter-professional collaboration as the process in which multiple health workers from different professional backgrounds work together with patients, families, caregivers, and communities to deliver the highest quality of care.

Research has shown that providing access to a team of professionals with a broad skill set provides for the prevention and management of chronic diseases thereby mitigating costly complications.[19] An effective implementation of a collaborative approach to primary health care can improve access to after-hours services, reducing the need for emergency rooms and after-hours clinics.[19]

Collaboration within a team is defined by the relationships and interactions that occur between team members who have a common goal. The level of required inter-professional collaboration varies depending on the complexity of health-care needs and the number of health-care professionals working to address those needs.[20] In the current health-care environment, no one health-care professional is equipped to provide for the complex and varied needs of patients. An inter-professional collaborative approach to care delivery is essential and will allow patients to receive the health care they need when they need it by the most appropriate health-care professional. In addition, the patient will benefit from the expertise and knowledge of a team of professionals rather than an independent practitioner.[21]

Panel Size

The establishment of a standard panel size for all family physicians is not possible, given the number of variables that can affect the workload generated by the nature of the panel and the practice style of the physician.[40] Nonetheless, the accountability benchmarks established by New Brunswick for family physicians remunerated in accordance with the Medical Pay Plan provides a baseline for determining minimum panel size for the family physicians. These guidelines will be utilized as the benchmark for establishing minimum panel size for physicians in FHTs.

Minimum panel size per physician ranges from 1,100 (with inpatient responsibilities including obstetrics and intra-partum care) to 1,800 (without inpatient responsibilities).[22] A physician's minimum panel size is increased by 400 patients when one FTE nurse is added, however no patients are panelled directly to the nurse.[22] Each one FTE nurse practitioner will have a minimum panel of 800 patients, which is added to the total panel size of the FHT.

Example: Minimum FHT Panel Size *(3 Physicians, 1 Nurse practitioner, 1 Nurse)*					
Physician	Physician	Physician	Nurse Practitioner (1 FTE)	Addition of Registered Nurse*	**Total FHT Panel Size**
**1,800	**1,800	**1,800	***800		**6,200**
133	133	133		Nurse (1FTE)	**6,600**

*see page 5 **no inpatient responsibilities *** patients paneled to NP

Electronic Medical Record (EMR)

EMRs are transformative because they inherently facilitate an enhanced delivery of care and change the productivity, work and processes in community-based practices.[23] The New Brunswick Electronic Medical Record system is a computer-based, inter-operable patient record which also integrates other applications to manage activities such as scheduling and billing.

The EMR's potential to improve patient health outcomes (e.g. patient safety, wait time reduction, management of chronic diseases) [24] is the fundamental driver for implementing the use of an EMR in community-based practice.

Guiding Principles

Family health teams will be information-driven organizations

Data captured electronically is used to make informed decisions. This includes appropriate information to drive evidence-informed care, clinical practice guidelines, care pathways, patient paneling for prevention, screening, and chronic disease management. This also includes collecting the necessary facts to drive performance management, quality improvement, program evaluation, and evidence-informed planning. [23, 24]

Family health teams promote and enable the sharing and integration of data

This applies internally within a FHT, to other FHTs, and externally to data shared with other organizations such as the Department of Health or the regional health authority. Internal data sharing supports team-based care, performance management, and quality improvement. External data sharing between FHTs supports integrated patient care, FHT comparability, and the concept of "one patient, one record". Data sharing and integration with other organizations supports care co-ordination, integrated planning and transparency and accountability to the government and to the public.

Improved outcomes may be achieved through more efficient sharing of patient information amongst health-care providers; thus supporting collaborative care. EMRs can also simplify the process for patient access to their own health information, making it easier for patients to participate in their own care. [23, 24]

However barriers such as cost, lack of resources, insufficient infrastructure and lack of expertise have contributed to a slower uptake of information systems across Canada. To effectively address these barriers, the New Brunswick Medical Society and the Department of Health have worked collaboratively to develop and implement an EMR system tailored to the New Brunswick context.

Velante was established by the New Brunswick Medical Society to support the 2012 launch of the provincial EMR program and provide the implementation, technology and infrastructure services to bring EMR to the province's physicians. For more information about New Brunswick's EMR program, visit: velante.com.

SECTION 3: Resourcing the Family Health Team

FHTs will be supported through a strategic realignment of existing resources from both within community-based and hospital-based environments for a more efficient and effective employment of current HHR, along with targeted investments in new resources (fiscal and HHR) for the team.

Health Human Resources

New resourcing based on a FHT with three primary health-care providers will be as follows:

- *FHT Co-ordinator*
- 1.0 FTE *registered nurse* (see page 5)*
- 1.0 FTE *allied health professional*

FHT Co-ordinator

The FHT co-ordinator (FHTC) will be employed by the regional health authority. Once the PHCN has established a list of potential candidates who meet the basic requirements of the position, the primary care providers who established the FHT will be involved in the selection process. They will select the candidate of their choice. The FHTC will provide support to teams as they move through the stages to becoming a fully operational team. Once this is achieved, the FHTC, as a permanent and integral member of the team, will provide co-ordinating and administrative support and ensure quality of services. The FHTC will also assume responsibility on behalf of the PHCN, for the collection and reporting of established health outcome and accountability measures. As long as the overall responsibilities outlined in the position description are respected, the role of the FHTC as a member of the team can be adapted to the particularities of each FHT. (Appendix B: Family Health Team Co-ordinator Position Description)

Registered Nurse (see page 5)*

The RN* will be hired directly by the FHT and is not an employee of the regional health authority. The addition of nursing resources (RN*) in instances where a FHT is comprised of more than the sum of three FTE primary health-care providers will be calculated in light of total panel size and community health needs.

The RN* will work to full-scope of practice in providing comprehensive primary health-care services and collaborate with other team members in program development, program planning, program delivery and evaluation. (Appendix A: Team Role and Responsibilities)

Allied Health Professional

Allied health professionals will be employees of the regional health authority and will assigned to FHTs by the PHCN based on the health needs identified in the CHNA. The addition of allied health professional resource in instances where a FHT is comprised of more than the sum of three FTE primary health-care providers will be calculated in light of total panel size and community health needs.

Allied health professionals will contribute meaningfully to the particular needs of the patient population and to the core activities of FHTs – chronic disease management, injury and disease prevention, health promotion and direct care services. (Appendix A: Team Roles and Responsibilities)

Nurse Practitioner(s)

The nurse practitioner(s) will be employees of the regional health authority and assigned to the FHT by PHCN based on the health needs identified by the CHNA. The nurse practitioner(s) will be directly responsible for patients panelled to his or her practice and will provide comprehensive health assessment, diagnose health or illness conditions and treat and manage acute and chronic illness. Nurse practitioners will also order and interpret screening and diagnostic tests, perform procedures and prescribe medications. (Appendix A: Team Role and Responsibilities)

Fiscal Resources

Each FHT will be eligible for a one-time start-up grant along with an ongoing annual operating grant. Start-up and ongoing operating costs associated with implementation of the provincial EMR will be included in the calculation of the grants along with funding for the nurse position.

Nurse: $80,000

Start Up Grant – base: $10,000 per physician

*Operating Grant – base: $5,000 annually

*Other: to be applied for on an individualized basis

*To be eligible for annual operating grants, teams must submit their agreed upon performance indicators. Over and above base operating grants may be eligible for additional funding support. Areas that will be considered in unusual annual operating costs incurred as a result of family health team practice include rent, equipment and supplies, team development and training, EMR licensing costs.

SECTION 4: Linking Community, Family Health Teams and the Primary Health-Care System

Engaging the Community and Other Stakeholders

Community engagement is the overall term used to refer to the whole span of activities that support the involvement of residents, community groups, service users, health providers, and businesses, in decision-making processes and in shaping and addressing issues that impact the health and well-being of the community. It provides an opportunity for diverse individuals to dialogue on health and wellness issues as well as involving the community in articulating a health and wellness vision. Articulating this vision and, in turn, identifying community assets as well as particular health care needs and strategies to address them is a first step in collaborating with the community in the development of a FHT.

Community Health Needs Assessments

A community health needs assessment (CHNA) is a dynamic, ongoing process undertaken to identify the assets, strengths and needs of the community and to enable community-wide establishment of wellness and health priorities that improve the health status of the population. The CHNA process encourages collaboration with community members, stakeholders and a wide variety of partners involved in decision-making processes within the health care system. Furthermore, it focuses public discussions on health issues and expectations of the health system, and increases understanding about the appropriate use of resources.[25]

It involves:

- Gathering information about health and wellness (facts and opinions);
- Gathering information about health and community resources (assets);
- Determining community priorities;
- Building partnerships to work on addressing community wellness and health needs using the assets and resources within the community.[25]

The New Brunswick Health Council identified 33 unique communities based on the 2011 Primary Health Care Survey. Each of these communities will undergo a CHNA. The results of the CHNA will assist communities and decision-makers in determining health needs within each community. In turn, this information will also assist FHTs in addressing health issues while capitalizing on existing assets and resources within the community.

Family Health Teams within a Primary Health Care Network

The primary health care network (PHCN) will function as the administrative body for FHTs and will support FHTs in attaining their overall objectives. The PHCN will be accountable to the Department of Health for the performance of each FHT.

At a minimum, one primary health care network (PHCN) aligned with each of the regional health authorities (RHAs) will serve to link the FHTs with the overall leadership of RHA. Each PHCN will be provided with appropriate administrative support and will be lead by a team of maximum of 10 persons, composed of representation from the leadership of the RHA and FHTs along with a community representative of the collaborative services committee. Two co-chairs will be selected— one FHT representative and one RHA representative.

The PHCN will assume responsibility for the planning, implementation and co-ordination of FHTs as follows:

a) Assure the appropriate allocation of fiscal and health human resources to the FHTs, based on the community health needs assessment and feedback from the FHT.

b) Provide support and guidance to emerging and existing FHTs and facilitate learning.

c) Collaborate with the RHA in responding to community needs and issues.

d) Ensure that health outcome and accountability measures are in place and monitored by FHTs and are aligned with the reporting requirements of the *Accountability Framework for Family Health Teams.* (Appendix C)

e) Provide reports to the Department of Health as per reporting requirements of the *Accountability Framework for Family Health Teams*. (Appendix C)

f) Address and resolve issues related to overall FHT expectations, performance and accountability. Escalate as necessary to the Department of Health as per escalation process guidelines.

Collaborative Services Committee

By and large, the CHNA process becomes an impetus for assembling the CSC. Ideally, this committee includes representation from local residents; community agencies including schools, nursing homes, and local businesses; other collaborative networks or committees, such as a Community Inclusion Network or Wellness Network; clergy; various government departments; and municipalities. The CSC will collaborate with the RHA in addressing the needs identified in the CHNA and build on the existing community assets by:

- Involving the community in strategic planning and needs assessment activities.
- Sharing information about community assets and resources.
- Providing input into the services and programs offered.
- Providing a forum to which issues affecting the health of the community may be directed.
- Serving as a link between the community and PHCN.

The composition and structure of the CSC is not prescriptive and communities will determine what works best for them, whether that be an annual forum open to everyone or a panel of selected members that will continue to meet on a regular basis.

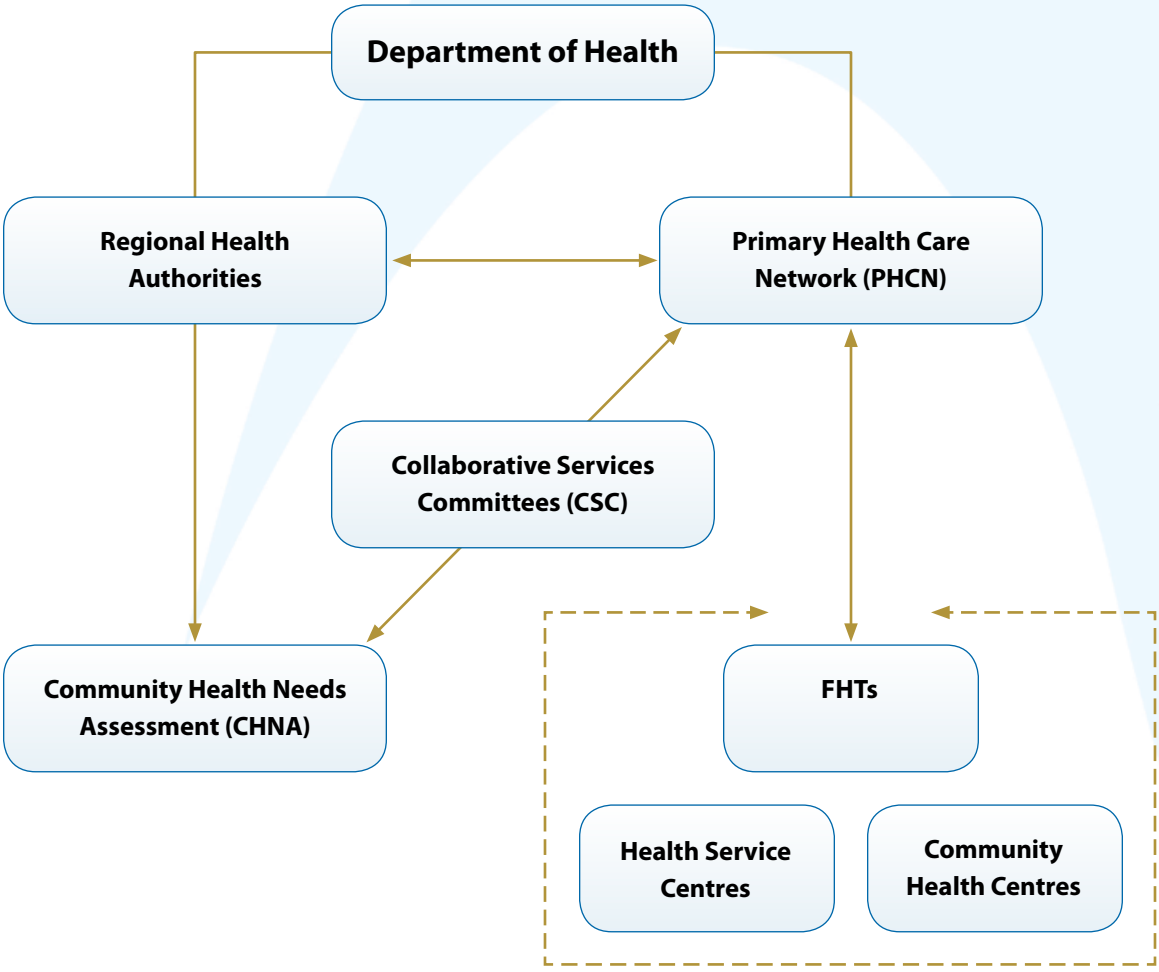
SECTION 5: Accountability and Performance Monitoring

Within the context of the FHT organization, **administration** is defined as the authority and responsibility for making decisions and taking action and the structure and processes used to direct the affairs of the organization. This structure defines the manner in which the affairs of the organization are managed and supervised and provides a shared understanding of the roles and responsibilities.[26] **Accountability** is the obligation to answer for results on matters for which the organization is responsible. For FHTs, this translates to both internal and external accountability in meeting service expectations, monitoring results and taking corrective action where necessary.[26]

Administrative responsibilities of FHTs include, but are not limited to, managing finances and HHR, establishing and evaluating accountability and participating in RHA strategic planning. At a minimum, each FHT must establish mechanisms to address the following areas of responsibility:

1. ***Human Resources Management***
   Ensure that mechanisms are in place to address matters that include addition, voluntary withdrawal and termination of health-care providers and staff as the case may be.
2. ***Risk Management***
   Establish appropriate risk management mechanisms, including appropriate liability and insurance coverage.
3. ***Accountability***
   Establish an internal organizational structure that defines roles, responsibilities and reporting relationships of FHT team members including:
   a) Selection of signing authority for banking and other documents, including reports to the government or the PHCN.
   b) Policies regarding patient record management, including safe-keeping and disposal.
4. ***Dispute Resolution***
   Adopt a process for dispute resolution that may arise among FHT members as it relates to internal and human resource management to avoid or mitigate possible complications.

Figure 1: Organizational Structure



Future Community Access Points

- Community Mental Health and Addictions
- Extra-Mural Program
- Public Health

Performance Measurement Reporting

Monitoring the performance of programs and services contributes to overall quality improvement and is a key component in achieving stated goals. Monitoring influences informed decision-making about resource allocation, policy direction, and system or program modification. More importantly, it impacts the quality of life for individuals who access primary health-care services.

FHTs are required to report performance through the measurement of defined indicators. More information about the accountability framework and its indicators are contained in Appendix C, *An Accountability Framework for Family Health Teams*.

A summary of the indicators for the Provincial Accountability Framework and reporting requirements follows.

Summary of Indicators: Provincial Accountability Framework

Operational Level Indicators (Provider/Patient)

Essential Indicators

The following six indicators must be collected within the first six months of the establishment of a FHT.

Measure	Target/Benchmark
1. General access	Decrease days to next available appointment by 20% up to a benchmark of within five days
2. Extended hours	Three sessions of extended hours per week (weekday evenings and/or weekends) based on size of FHT
3. After hours arrangement	Present
4. Interdisciplinary team established	Present
5. EMR uptake	Present
6. Patient Registration	Achieving established minimum requirements

Baseline Indicators

Data must be reported within **year one** of the establishment of FHT. Baseline data will be collected by the FHT Co-ordinator by means of a standardized patient survey and repeated every two years*.

Measure	Target/Benchmark
1. Patients feel they were given enough time to discuss their health	Increase by 10%, benchmark 85%
2. Patients feel they are involved in decision-making	Increase by 10%, benchmark 85%
3. Patients who feel they can manage or control their health condition	Increase by 10%, benchmark 50%
4. Extent to which health professional helped patient manage their health condition	Increase by 10%, benchmark 90%
5. Percent of diabetes patients who have achieved an A1C level of 7 percent or less	Increase by 5%, benchmark 60%
6. Use of the Emergency Room (ER)	Decrease by 5%, benchmark 30%
7. Patients who know what their medications are for	Increase by 5%, benchmark 50%
8. Flu shot given to persons 65+	Increase by 5%, benchmark 80%
9. Chronic Disease Patients: Blood pressure measurement	Increase by 5%, benchmark 95%
10. Chronic Disease Patients: Blood sugar testing-diabetes patient	Increase by 5%, benchmark 90%
11. Chronic Disease Patients: Body weight measurement	Increase by 5%, benchmark 80%
12. Chronic Disease Patients: Cholesterol testing	Increase by 5%, benchmark 85%

*After two years, benchmarks and measures will be reviewed by the PHCN and adjusted if required.

System Level Indicators

System level indicators monitor the overall effect of the primary health care reform strategies. The data for all system level indicators will be collected by the Primary Health Care Network and reported to the Department of Health.

Measure	Target/Benchmark
1. Percent of patients who can get same day/next day appointments	Increase by 5%, benchmark 45%
2. After hours arrangement	Increase by 5%, benchmark 50%
3. Access to FHTs	Increase by 5%, benchmark 50%
4. Primary health care provider helps to co-ordinate with other providers	Increase by 5%, benchmark 75%
5. Percent of population who rate their primary health care services an 8, 9 or 10 on a scale of zero to 10.	Increase by 5%, benchmark 85%
6. Percent of diabetes patients who have achieved an A1C level of 7 percent or less	Increase by 5%, benchmark 60%
7. Percent of Patients in the Obese Category	Decrease by 10%, benchmark 20%
8. Rate of patients hospitalized for Ambulatory Care Sensitive Conditions	Decrease by 5%, benchmark 300/100,000 population
9. Patients who know what their medications are for	Increase by 5%, benchmark 50%
10. Percent of population 65 and over receiving a flu shot	Increase by 5%, benchmark 80%
11. Test results and records are available at visit	Increase by 5%, benchmark 95%

SECTION 6: Professional Liability

Professional Liability

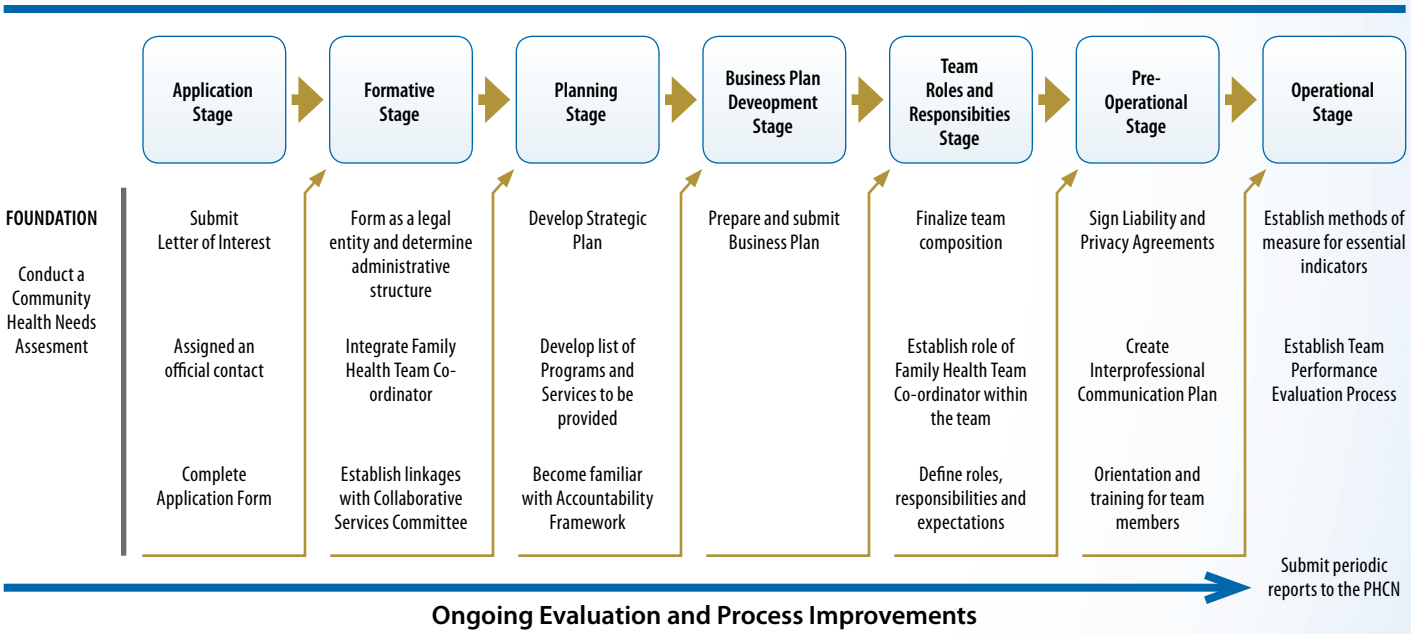
Despite the potential benefits of interdisciplinary collaboration between health professionals, many remain hesitant in part due to concerns with increased liability risks and potential accountability for the negligence of their colleagues. However, the Conference Board of Canada (2007),[27] the Canadian Medical Protective Association (2006)[28] and the Canadian Nurses Protective Society (2006)[29] state that this should not be a barrier to implementing collaborative practices.

This concern is the result of a misperception of types of liability. Distinction needs to be made between direct liability and vicarious liability. In direct liability, each health-care professional is accountable for his or her own professional practice.[27] In a case of negligence in patient care, the individual professional is responsible.[27] Physicians who have worked independently in private practice have assumed that they would be responsible and accountable for another team member's actions.[28] However, the Canadian Medical Protective Association maintains that this confusion is a result of no clear distinction of who the employer is in a collaborative model of practice. In an independent practice, the physician takes on the role of employer, thereby assuming the vicarious liability.[28] However, it is important to note is that each health-care professional on a team is accountable for their own standards of practice and competency to provide care. Physicians are only responsible for their own actions.[27] To date, Canadian courts have assessed liability against individuals in cases involving health-care professionals working as a team.[27, 28]

SECTION 7: The Roadmap to Implementing a Family Health Team

The *Roadmap to Implementing a Family Health Team*[32, 33, 34] is intended as a guide to the development and establishment of a FHT. The process has been divided into seven distinct sections beginning with the application stage through to the final stage where the team has become fully operational.

Figure 2: New Brunswick FHT Development Roadmap



Application Stage

Upon completion of a CHNA, a group of three or more primary health-care providers may voluntarily submit a letter of interest to the primary health care network or the primary health care steering committee in instances where the PHCN is not yet established for the particular community.

Once the letter of interest has been received and approved, applicants will be assigned an official contact from the PHCN or the Department of Health, who will provide guidance and assistance with application requirements and ensure familiarity with the key elements of the FHT Operating Guidelines.

In summary the prospective applicants will:

- Assess the results of the community health needs assessment.
- Submit a letter of interest to the PHCN (or PHCSC).
- Upon approval, complete and submit FHT application.
- Receive the services of an official contact to assist with the application process.

Formative Stage

Once the application has received formal approval, the team will be instructed by the PHCSC (later the PHCN) to proceed with the development of a FHT. At this stage, the physicians of the team must form a legal entity (corporate, not-for profit) and determine an appropriate governance structure.

It is at this stage that the FHT co-ordinator should be joining the team as this individual will play an important role in the establishment of linkages with the community and the collaborative services committee.

In the **Formative Stage**, a prospective FHT will:

- Establish linkages with the Collaborative Services Committee (CSC).
- Add the FHT co-ordinator to the team.

Strategic and Program Planning Stage

The FHT co-ordinator will assist the team in developing a strategic plan in collaboration with the CSC that includes a vision, a mission, short term goals, long-term goals and objectives. The strategic plan will help determine the composition of the team and help to clarify roles and responsibilities for team members. Strategic planning should assist the FHT in developing an approach to services, including how the team will address population health needs.

The strategic planning exercise, the results of the CHNA and the input from the CSC will help shape the list of the programs and services that the FHT will provide to best meet the needs of the community. A familiarity with the *Accountability Framework for Family Health Teams* (see Appendix C) will help ascertain how programs and services are delivered and establish how outcomes will be measured and reported once the FHT is operational.

At the **Strategic and Program Planning Stage** a prospective FHT will:

- Develop a strategic plan (vision, mission, short and long term goals, and objectives).
- Develop a list of programs and services your FHT wishes to provide.
- Become familiar with the Accountability Framework for Family Health Teams.

Business Plan Development Stage

The FHT co-ordinator will assist with the development of the business plan. The business plan should include the following:

- Executive summary.
- Community or service area profile.
- Mission and vision.
- Administration and leadership structure.
- Service delivery framework and strategies.
- Staffing plan.
- Facilities and equipment infrastructure.
- Performance monitoring, methods of measure and results reporting.

Once the business plan is approved by the PHCN, the staffing complement of the team will be confirmed and along with funding for one-time costs and additional operating costs.

At the **Business Application Stage**, a prospective FHT will:

- Prepare a detailed business plan.
- Receive approval for funding.

Defining Roles and Responsibilities of Team Members

Defining practitioner roles and responsibilities will enhance the positive elements of the FHT model and reduce the possibility of ambiguity and misunderstanding regarding protocols, procedures, responsibility and authority. Appendix A: *Team Roles and Responsibilities* offers an outline of the roles and responsibilities by provider, based on their regulated scopes of practice. For more information on the scope of practice of each health-care professional, please contact the regulatory college as indicated under each description.

At the **Defining Roles and Responsibilities of Potential Team Members Stage**, a prospective FHT will:

- Finalize team membership.
- Define roles, responsibilities and expectations of team members.
- Develop the role FHT co-ordinator as a member of the FHT.
- Sign memorandum of understanding with Primary Health Care Network or Department of Health.

Pre-Operational Stage

At this stage, the team is in final preparations to begin working collaboratively in an inter-professional environment. The development of an inter-professional communication plan will ensure that all health-care team members practice to their full scope and understand and demonstrate respect for the unique and shared competencies of other health-care team members. Practitioners must also be accountable for and committed to maintaining effective communications with other members of the inter-professional health-care team, and promote team problem-solving, decision-making and collaboration by applying principles of group dynamics and conflict resolution.[34]

The identification of pertinent training and educational sessions can be carried out in collaboration with the FHT co-ordinator who will be responsible for planning and organizing the delivery of the training. As all team members should be identified at this stage, it is appropriate to have all applicable liability and privacy agreements in place.

At the **Pre-Operational Stage**, a prospective FHT will:

- Develop an inter-professional communication plan.
- Plan for and arrange training and educational sessions for your team.
- Sign liability and privacy agreement.

Operational Stage

By this time, the FHT will have acquired its full complement of team members. Periodic evaluation and feedback on individual and team performance plays a vital role in team development and its capacity to achieve set goals. The development of a team-based performance evaluation plan will ensure that the team remains focused on continuous improvement. Two levels of performance evaluation exist. The first is an internal evaluation of each team member's relationship to the others, as well as the individual's contribution to the team. The second focus relates to the team's performance against the expected outcomes for meeting the needs of the patients it serves.[32]

The *Accountability Framework for FHTs* provides the information on FHT outcome indicators along with mandatory reporting requirements. The team should be well-acquainted with this information and work collaboratively with the FHT co-ordinator to identify methods of measure and reporting on the required outcome indicators.

At the **Operational Stage**, a FHT will:

- Define measurement methods for each indicator.
- Establish team performance evaluation process.
- Submit periodic service and other reports to the PHCN.

Definitions

After-hours Care
Care and advice for patients or appropriate direction for care, in the evenings, week-ends and holidays.

Accountability
The obligation to demonstrate that policies and programs are achieving intended results.[37]

Community health centre
Organizations that provide primary health-care services, illness/injury prevention, chronic disease management and community development using a population health approach in an interdisciplinary team of health providers.[38]

Community Inclusion Network
An organization developed through a collaborative process; its members are groups and individuals from all sectors who have an interest in promoting socioeconomic inclusion. Community Inclusion Networks work together to identify regional issues and priorities, and implement initiatives to address them.

Dimensions of quality
The general quality of services in the health care system as measured by accessibility, appropriateness, effectiveness, efficiency, equity, and safety factors.

Dimensions of quality: Accessibility
The ability of patients/clients to obtain care/service at the right place and the right time, based on their respective needs, in the official language of their choice.

Dimensions of quality: Appropriateness
Care/service provided is relevant to the patients'/clients' needs based on established standards.

Dimensions of quality: Effectiveness
The care/service, intervention or action achieves the desired outcome.

Dimensions of quality: Efficiency
Achieving the desired results with the most cost-effective use of resources .

Dimensions of quality: Equity
Providing quality care/service to all, regardless of individual characteristics and circumstances, such as race, color, creed, national origin, ancestry, place of origin, language, age, physical disability, mental disability, marital status, family status, sexual orientation, sex, social status, belief or political activity.

Dimensions of quality: Safety
Potential risks of an intervention or the environment are avoided or minimized.

Extended hours
Hours of operation beyond regular business hours (9 am – 5 pm Monday through Friday)

Extra Mural Program
Provides comprehensive home health-care services to New Brunswickers of all ages in their homes and in their communities. The Extra-Mural professionals provide health-care services that include: assessment, interventions (including treatment, education and consultation), service planning and co-ordination. The program also provides palliative services to support the quality of life for individuals with progressive life-threatening illnesses.[39]

Full-time equivalent (FTE)
Defined as the "measure used to estimate whether a health care professional is working full-time. In the case of FFS physicians " It is a weighted count, based on total fee-for-service payments received. A physician's FTE value is calculated using his or her total payments in relation to upper and lower benchmarks for that specialty in that jurisdiction. [40]

Health outcomes
Changes in health status of an individual, group or population from a system perspective.

Health service centre
Primarily located in rural areas and provide nursing and administrative support to fee for service physicians in an office practice setting.

Health system or Health-care system
Includes all individuals, institutions, and resources, involved in the prevention, treatment and management of injury, illness and disability and the preservation of mental and physical well-being through the services offered in the province by medical, nursing and allied health professions.

Indicator
"A measurement tool, which is rate-based or defined as an event, that is used as a guide to monitor, evaluate and improve the quality of patient care and services, clinical support services and organizational functions, in order to make continuous improvements" (Accreditation Canada).

Interdisciplinary collaboration
Refers to the positive interaction of two or more health professionals, who bring their unique skills and knowledge, to assist patients/clients and families with their health decisions. [41]

Interdisciplinary teamwork
Involves people from multiple disciplines and professions working together to achieve a common goal. Interdisciplinary teamwork provides a forum for problem-solving and shared decision-making; allows for pooling of expertise and flexible leadership; and offers opportunities for personal growth and development. Within a health setting, professionals come together to discuss the individual's status and the evolving plan of care.

Multidisciplinary teamwork
Involves people of various disciplines working collaboratively on a common project but in a parallel fashion. In a health setting, several professionals work independently with the same individual and communicate with colleagues primarily through the individual's written record.

Panel size
The number of individual patients under the care of a specific provider. A panel is the formalized linkage and long-term, ongoing relationship between a primary care physician or nurse practitioner and his/her patients.

Patient-centered care
Respect for people's values, preferences, and expressed needs; the co-ordination and integration of care; information, communication, education, physical comfort; emotional support and alleviation of fear and anxiety; the involvement of family and friends; and transition and continuity.[42] Empowered patients and their families are essential members of the team and active participants in their health care decision-making.

Performance
The degree of progress achieved toward stated goals and objectives, while monitoring is the act of observing, recording and reporting performance information. Goals are general statements which convey the policy direction or strategic aims of an organization. Objectives are more specific, measurable statements of intent.

Performance indicators
Markers or measures which convey quantifiable information about progress towards goals and objectives.

Performance measurement
The ability to monitor measure and evaluate the quality of health services offered by FHTs based on eight dimensions of quality: Accessibility, Integration, Patient Centered, Effectiveness, Efficiency, Safety, Appropriateness, Appropriate resources

Population health
An approach to health that aims to improve the health of the entire population and to reduce health inequities among population groups. In order to reach these objectives, it looks at and acts upon the broad range of factors and conditions that have a strong influence on our health.[43]

Primary health care
An approach to health that includes a range of services that go beyond those of the traditional health care system to include all services that influence health. Primary care is "the element within primary health care that focuses on health-care services, including health promotion, illness and injury prevention, and the diagnosis and treatment of illness and injury".[44]

Primary health-care teams
A primary health-care team in New Brunswick is an interdisciplinary group of primary health-care professionals, including family physicians, working to their full scope of practice, brought together (either co-located or virtually) to deliver 24/7, comprehensive, patient-centered primary health care to meet specific health needs of the community in which they serve.

Regular business hours
Hours during the day in which business is commonly conducted, typically weekdays from 9 am to 5 pm

Tele-care
Tele-Care (or 811) is a free and confidential telephone line to get medical information or health advice from a registered nurse.

Unattached or orphan patients
A patient not known to have a regular attending physician.

Wellness Networks
Promote healthy eating, increased physical activity and/or other wellness goals through family-friendly activities and events such as walking clubs, community gardens, cooking lessons for adults and children, and more.

Zones (Health Zone)
New Brunswick is divided into seven zone boundaries, as defined by Statistics Canada, that are currently used for higher level statistical reporting for the population.

Zone 1: Moncton/South-East
Zone 2: Fundy Shore/Saint John
Zone 3: Fredericton/River Valley
Zone 4: Edmundston
Zone 5: Restigouche
Zone 6: Bathurst/Acadian Peninsula
Zone 7: Miramichi

Operation Services Committee Member List

Mandate:

- *Develop an Operational Guide for Family Health Teams*
- *Develop an accountability Framework for Family Health Teams*

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Appendices

Appendix A: Team Roles and Responsibilities [45,46,47,48]

Purpose

A mutual understanding of the scope of practice, roles and responsibilities of each member of the FHT is essential to the effectiveness of the team. Additionally, the patient, as a team member, should also be knowledgeable of the roles and responsibilities of their health-care providers.[48.] Clearly defining roles and responsibilities has been shown to reduce ambiguity and misunderstandings regarding protocols, procedures, responsibilities, and authority.

While not an exhaustive review of health professionals and their functions within a FHT, the following inventory of roles and responsibilities is intended to provide assistance in the establishment, oversight, and accountability of interdisciplinary teams.[45, 46]

For more information on each of the health professions, please refer to the regulatory college and association contact information at the end of each section.

Each section includes the following information for each health-care practitioner: definition of profession, roles and responsibilities as member if an interdisciplinary team, and contact information.

Physician

Definition of Profession:

The term medical practitioner means a person lawfully entitled to practice medicine in the place in which such practice is carried on by him.

— *New Brunswick Medical Services Payment Act,* RSNB, 1973, c M-7

As Members of an Interdisciplinary Team:

The key role of the family physician is to provide continuous care to individual patients and their family members over the course of a person's lifetime. As a result of a physician's knowledge of their patient, the family and the community, the physician is usually the first health-care professional that a patient requiring health care, support, or information will access. A physician will assist in co-ordination of care, ensure that the patient has the ability to directly access any other member of the FHT, and will help the patient navigate the health-care system.

The Canadian Medical Association states that a physician is best positioned to assume the role of clinical leader in collaborative care teams by virtue of training, knowledge, background, and patient relationship. The physician may delegate clinical leadership to another health-care professional; moreover, other health-care professionals may be best suited to act as team co-ordinator (co-ordinate services by the team to enhance integration and provide best care).[39]

Roles and Responsibilities:

- Assessments, including performing health assessments, screening at-risk patients, followed by diagnoses, primary medical treatment and advice for management of acute medical conditions and injuries.
- Provide treatment and management by providing the following services: primary mental health care, screening for sexually transmitted infections (STIs), primary reproductive care, palliative care, hospital care (where required), early intervention and counseling, immunizations, monitoring and prevention of chronic illnesses, and acute medical treatment for a range of medical problems.
- Education and advocacy though providing counseling on health issues (i.e. birth control, prevention of disease, prevention of STIs).
- Provide clinical leadership through synthesizing and interpreting the evidence and data provided by the patient and the team to make a differential diagnosis and deliver comprehensive care for the patient. The clinical leader is ultimately accountable for making definite clinical decisions.[45]
- Collaborate with other health-care providers and co-ordinate patient care.
- Co-ordinate referrals to other health-care providers and agencies as well as secondary and tertiary facilities based on patient's needs.

For further information:

New Brunswick Medical Society
21 Alison Blvd
Fredericton NB E3C 2N5

Telephone: (506) 458-8860
Website: http://www.nbms.nb.ca

College of Physicians and Surgeons of New Brunswick
One Hampton Road, Suite 300
Rothesay NB E2E 5K8
(Contact: Dr. Ed Schollenberg, Registrar)

Telephone: 506-849-5050 or 800-667-4641
Website: http://www.cpsnb.org

College of Family Physicians of Canada
2630 Skymark Avenue
Mississauga ON L4W 5A4

Telephone: 905-629-0900
Website: http://www.cfpc.ca

Canadian Medical Association (head office)
1867 Alta Vista Drive
Ottawa ON K1G 3Y6

Telephone: 800-457-4205 (toll-free)
Website: http://www.cma.ca

Nurse Practitioner

Definition of Profession:

Nurse practitioner competencies reflect advanced nursing practice by building and expanding upon the competencies required of a registered nurse. Nurse practitioners are autonomous health professionals with advanced education who provide essential health services grounded in professional, ethical and legal standards. They integrate their in-depth knowledge of advanced nursing practice and theory, health management, health promotion and disease/injury prevention, and other relevant biomedical and psychosocial theories to provide comprehensive health services. Nurse practitioners work in collaboration with their clients and other health care providers.

As Members of an Interdisciplinary Team:

Nurse practitioners in New Brunswick practice under a competency- based framework. Roles and responsibilities listed below are not all inclusive, meaning that NPs can expand their role as required when health-care delivery systems change. The nurse practitioner in primary health care is a generalist who offers comprehensive and continuous care to clients across the health continuum and throughout the client's lifespan. Safe, competent, ethical nurse practitioner practice requires the integration and performance of many competencies simultaneously. Nurse practitioners have the competence to provide comprehensive health assessment, to diagnose health/illness conditions and to treat and manage acute and chronic illness within a holistic model of care. Nurse practitioners order and interpret screening and diagnostic tests, perform procedures and prescribe medications while integrating the principles of resource allocation and cost-effectiveness, in accordance with federal and provincial legislation and policy.

Roles and Responsibilities ***(in addition to those listed for registered nurses):***

- Perform a focused health assessment and/or an advanced comprehensive health assessment, using and adapting assessment tools and techniques based on client needs and relevance to client stage of life;
- Perform a complete or focused health history appropriate to client situation including physical, psychosocial, emotional, ethnic, cultural and spiritual dimensions of health;
- Perform a complete or focused physical examination, and identify and interpret normal and abnormal findings as appropriate to client presentation;
- Synthesize health assessment information using critical inquiry and clinical reasoning to diagnose health risks and states of health/illness;
- Formulate differential diagnoses through the integration of client information, and evidence-informed practice;
- Anticipate and diagnose emergent, urgent and life-threatening situations; Order and/or perform screening and diagnostic investigations, interpret results using evidence-informed clinical reasoning and critical inquiry, and assume responsibility for follow-up;
- Diagnose diseases, disorders, injuries, conditions and identify health needs, while considering the client response to the health/illness experience;
- Communicate with clients about health assessment findings and/or diagnosis, including outcomes and prognosis;
- Determine care options and initiate therapeutic interventions in collaboration with clients, while considering client perspectives, feasibility and best outcomes;
- Initiate interventions for the purpose of stabilizing clients in emergent, urgent and life threatening situations;

- Support, educate, coach and counsel clients regarding diagnoses, prognoses, and self-management including their personal responses to diseases, disorders, conditions, injuries, risk factors, lifestyle changes and therapeutic interventions;
- Perform invasive/non-invasive procedures for the clinical management and/or prevention of disease, injuries, disorders or conditions; and
- Prescribe pharmacotherapy based on the client's health history, disease, disorder, condition and stage of life and individual circumstances.

For further information:

The Nurses Association of New Brunswick
165 Regent Street
Fredericton NB E3B 7B4

Telephone: 506-458-8731 or 800-442-4417 (toll-free)
Website: http://www.nanb.nb.ca

Standards of Practice for Registered Nurses available at: http://www.nanb.nb.ca/downloads/NANB%20Standards%20of%20Practice%20for%20Registered%20%20Nurses%202012_E.pdf

Registered Nurse

Definition of Profession:

Nursing means the practice of nursing and includes the nursing assessment and treatment of human responses to actual or potential health problems and the nursing supervision thereof.

— *Nurses Act,* 1984

As Members of an Interdisciplinary Team:

Registered nurses in New Brunswick are educated as generalists and practice under a competency-based framework. However, because of advances in research and technology, and changes in health care delivery systems, the practice of registered nurses needs to evolve to respond to clients' care needs. Therefore, the dynamic nature of nursing practice requires that RNs continue to acquire knowledge and skills throughout their career. Roles and responsibilities listed below are not all inclusive, meaning that registered nurses can expand their role as required when healthcare delivery systems change. RNs have knowledge and decision-making skills in health assessment, health promotion, health care management, rehabilitation and support services and community development and planning.

Roles and Responsibilities:

- Practice in accordance with relevant legislation, standards, and employer policies;
- Practice in accordance with the Code of Ethics for Registered Nurses;
- Is answerable for nursing actions, decisions and professional conduct;
- Take measures to maintain fitness to practice such that client safety is not compromised;
- Recognize and take action in situations where client safety is actually or potentially compromised;
- Use critical inquiry in collecting and interpreting data, in determining and communicating client status, in planning and implementing the plan of care and in evaluating outcomes;
- Assign and delegate nursing activities in accordance with client needs, the roles and competence of other providers and the requirements of the practice setting
- Holistically assess patient health care needs and provide triage.

- Determine the appropriate service or treatment, the appropriate care provider and/or the appropriate equipment.
- Prevention, screening and management of chronic disease(s).
- Initiation of directives, including but not limited to treatments, immunizations, wound care and glucose monitoring.
- Health education and support for individuals and groups to increase capacity for self-care (i.e. teaching patients about lifestyle, nutrition, parenting, medication, breastfeeding, smoking cessation, STI/HIV education and prevention, and pregnancy counseling).
- Collaborate with other health-care providers and co-ordinate patient care.

For further information:

The Nurses Association of New Brunswick
165 Regent Street
Fredericton NB E3B 7B4

Telephone: 506-458-8731 or 800-442-4417 (toll-free)
Website: http://www.nanb.nb.ca

Registered Dietitian

Definition of Profession:

The practice of dietetics means the translation and application of scientific knowledge of foods and human nutrition towards the attainment, maintenance and promotion of the health of individuals, groups and the community and includes the following:

a) Administering food service systems through this function is not exclusive to dietitians;

b) Assessing nutritional needs of individuals and developing and implementing nutritional care plans based on the assessments;

c) Establishing and reviewing the principles of nutrition and guidelines for healthy and ill people throughout their lives;

d) Assessing the overall nutritional needs of a community in order to establish priorities and to influence policies which provide the nutritional component of preventative programs, and implementing and evaluating those programs;

e) Interpreting and evaluating, for consumer protection, information on nutrition that is available to the public;

f) Consulting with individuals, families and groups on the principles of food and nutrition and the practical application of those principles;

g) Planning, conducting and evaluating educational programs on nutrition;

h) Conducting basic and applied research in food, nutrition and food service systems though this function is not exclusive to dietitians.

— The *Act Respecting the New Brunswick Association of Dietitians,* 1988, c.75

As Members of an Interdisciplinary Team:

Dietitians can contribute to health promotion and illness prevention strategies, and develop specialized nutrition therapy and rehabilitation support strategies to address specific nutrition-related illnesses.

Roles and Responsibilities:

- Work with patients to determine nutritional needs;
- Conduct nutritional and weight assessments;
- Develop nutritional plans based on comprehensive needs assessments;
- Provide nutritional and weight management counseling;
- Promote behavior change related to food choices, eating behavior, and preparation methods to optimize health;
- Promote patient independence and autonomy in decision-making for patient to achieve optimal personal health and well-being;
- Identify community capacities and facilitate community skill-building, health advocacy, and social action;
- Work with physicians on medication monitoring plans as they relate to nutrition;
- Communicate relevant nutritional information to other health-care providers;
- Collaborate with other health-care providers and co-ordinate patient care.

For further information:

New Brunswick Association of Dietitians
530 Main Street
Woodstock NB E7M 2C3
Telephone: 506-324-9396
Email: registrar@adnb-nbad.com
Website: https://www.adnb-nbad.com

Dietitians of Canada
480 University Avenue, Suite 604
Toronto ON M5G 1V2
Telephone: 416-596-0857
Website: http://www.dietitians.ca

The *Act Respecting the New Brunswick Association of Dietitians,* 1988, c.75, available at:
https://www.adnb-nbad.com/PDF%27s/NBAD_ACT_Assented_Dec_8_1988.pdf

Pharmacist

Definition of Profession:

The practice of pharmacy promotes health, the prevention and treatment of diseases, dysfunction and disorders through proper drug therapy and non-drug therapy, including, but not limited to, the following actions:

a) Assist and advise clients, and other healthcare providers by contributing unique drug and non-drug therapy knowledge on drug and non-drug selection and use,
b) Monitor responses and outcomes to drug therapy,
c) Compound, prepare, dispense and administer drugs,
d) Provide non-prescription drugs, blood products, parenteral nutrition, health care aids and devices,
e) Supervise and manage drug distribution systems to maintain public safety and drug system security,

f) Educate clients, and members of the society (New Brunswick Pharmaceutical Society) in matters described in this section,

g) Conduct or collaborate in drug related research,

h) Conduct or administer drug and other health-related programs,

i) Advise and support other pharmacists in the provision of pharmacy services,

j) Direct the client to consult with other health-care providers when appropriate.

— The *New Brunswick Pharmacy Act,* 1983, c.100

As Members of an Interdisciplinary Team:

Pharmacists on site in primary health-care settings showed greater identification of medication-related problems and improved completeness of medication lists, documentation of allergies and adverse events, increased appropriateness of medication use, and, in some instances, better control of conditions like diabetes, hypertension, and hyperlipidemia.

Roles and Responsibilities:

- Ensure appropriate patient information is gathered and recorded;
- Review patient profile including known patient risk factors for adverse drug reactions, drug allergies, known contraindications to prescription drugs, nonprescription drugs, natural health products, and complementary or alternative medicines;
- Evaluate patient drug therapy and identify potential and actual drug-related problems and determine appropriate therapeutic options to resolve or prevent them;
- Conduct patient assessments for medication problems;
- Manage medication through home follow-ups and monitoring of patient compliance;
- Provide education to patients to facilitate understanding of his/her drug therapy;
- Educate and update other health professionals on the team with respect to most current drug related guidelines and evidence-based research;
- Refer patient to appropriate healthcare providers within the FHT if necessary;
- Communicate with physician(s) to help the patient achieve maximum benefit from drug therapy and to prevent medication errors or potential significant adverse reactions;
- Collaborate with other health-care providers and co-ordinate patient care.

For further information:

New Brunswick Pharmacists' Association
212 Queen Street, Suite 410
Fredericton NB E3B 1A8

Telephone: 1-888-358-2345 or 506-459-6008
Email: nbpa@nbnet.nb.ca
Website: www.nbpharma.ca

New Brunswick Pharmaceutical Society
1224 Mountain Road, Unit 8
Moncton NB E1C 2T6

Telephone: 1-800-463-4434 or 506-857-8957
Website: http://www.nbpharmacists.ca

Canadian Pharmacists Association
1785 Alta Vista Drive
Ottawa ON K1G 3Y6

Telephone: 1-800-917-9489 or 613-523-7877
Email: info@pharmacists.ca
Website: http://www.pharmacists.ca/index.cfm

The ***New Brunswick Pharmacy Act,*** 1983, c.100, available at:
http://www.nbpharmacists.ca/LinkClick.aspx?fileticket=T93d9fQewn4%3d&tabid=244&mid=686

Physiotherapist

Definition of Profession:

Physiotherapy and practice of physiotherapy means the scientific application of physiotherapy knowledge, skill and judgment in optimizing functional independence and mobility, preventing and managing pain, and promoting health and wellness based on the art and science of therapeutic movement and through an evidence-based approach to assessment, identification of a physiotherapy diagnosis, intervention, and outcome evaluation including:

a) The selective application of a broad range of physical and physiological interventions including therapeutic exercise, massage and manipulation, radiant, mechanical, and electrical energy or acupuncture;

b) The planning, administration and evaluation of preventative, therapeutic and health maintenance programs; and

c) The provision of consultation, education, research, and other physiotherapy services.

— *Act Respecting the College of Physiotherapists of New Brunswick,* 2010, Bill 27

As Members of an Interdisciplinary Team:

Physiotherapists in primary health care play a significant role in health promotion injury and disease prevention, and in analyzing the impact of injury, disease or disorders of movement and function. Physiotherapists are the ideal health professionals to act as both providers and consultants in the area of specialized exercise programming.

Roles and Responsibilities:

- Assess physical abilities, the impact of an injury or disability on physical functioning, physical preparation for work and sports, and evaluate overall functional ability;
- Plan treatment programs and provide treatment of an injury or disability through individualized exercise programs, manual therapy, modalities, and patient/family education and home exercise prescriptions;
- Educate to restore movement and reduce pain and encourage and enable patient(s) to take charge of their health;
- Collaborate with other health-care providers and co-ordinate patient care.

For further information:

College of Physiotherapists of New Brunswick
82 Germain Street, Suite 2C
Saint John NB E2L 2E7

Telephone: 506-642-9760
Website: http://www.cptnb.ca

New Brunswick Physiotherapy Association / Atlantic Provinces Physiotherapy Associations
PO 28117
St. John's NL A1B 4J8

Email: lisapike02@bellaliant.net
Website: http://www.atlanticphysiotherapyassociations.com

Canadian Physiotherapy Association
935 Green Valley Crescent, Suite 270
Ottawa ON K2C 3V4

Telephone: (613) 564 – 5454 or (800) 387-8679
Email: information@physiotherapy.ca
Website: http://www.physiotherapy.ca

Act Respecting the College of Physiotherapists of New Brunswick, 2010, B. 27, accessible at:
http://www.cptnb.ca/2010_Docs/Bill-27.pdf

Occupational Therapist

Definition of Profession:

The practice of occupational therapy means the art and science which utilizes the analysis and application of selected rehabilitative, education and vocational activities to restore maintain and enhance performance throughout the life-span, in the areas of self-care, productivity and leisure and without limiting the generality of the foregoing, addresses problems impeding functional independence in order to:

a) Maintain and promote existing healthy functions,

b) Diminish pathology and restore function,

c) Facilitate learning of skills essential for adaptation and productivity, and

d) Modify activities, equipment and environment to enable clients to achieve their highest level of independent and quality of life.

— Act Respecting the New Brunswick Association of Occupational Therapists, 1988, Chapter 76

As Members of an Interdisciplinary Team:

Occupational therapists have demonstrated positive outcomes in primary health care roles with populations of seniors, children, youth, workers, homeless people and those with mental health problems.[46] In a review of the literature on evidence supporting occupational therapy in primary health care settings, Restall, LeClair and Fricke (2005),[47] noted strong evidence to support occupational therapy roles to support management of rheumatoid arthritis, stroke, chronic low back pain, return to work, and the prevention of falls and functional decline in older adults. Occupational therapists will contribute meaningfully to the core activities of FHTs— chronic disease management, injury and disease prevention, health promotion and direct care services.

Roles and Responsibilities:

- Assessment of physical, emotional and cognitive functioning with environmental considerations;
- Evaluation of the home, work, and/or school environment(s) to assess the need for specialized equipment modifications and/or supports;
- Teaching daily living and community life skills;
- Individualized treatment plans to develop, maintain, or augment function using evidence based treatment modalities;
- Education and counseling of patients and caregivers regarding the impact of disability, injury and disease and the importance of prevention and their role in care and recovery;
- Refer patient to other health-care professionals within the team and/or community services needed;
- Promote comprehensive and co-ordinated care through collaboration with other health-care professionals.

For further information:

New Brunswick Association of Occupational Therapists
PO 184, Station A
Fredericton NB E3B 4Y9

Telephone: (506) 458-1001
Email: info@nbaot.org
Website: http://www.nbaot.org

Canadian Association of Occupational Therapists
CTTC Building
1125 Colonel By Drive, Suite 3400
Ottawa ON K1S 5R1

Telephone: (613) 523-2268 or (800) 434-2268
Website: http://www.caot.ca

Social Worker

Definition of Profession:

The practice of social work includes the assessment, remediation and prevention of social problems, and the enhancement of social functioning of individuals, families, groups and communities by means of:

a) The provision of direct counselling services within an established relationship between a social worker and client;

b) The development, promotion, and delivery of human service programs, including that done in collaboration with other professionals;

c) The development and promotion of social policies aimed at improving social conditions and promoting social equality; and

d) Any other activities consistent with the objects of the Association.

— The *New Brunswick Association Social Worker's Act,* 1988, c.82

As Members of an Interdisciplinary Team:

Social workers specialize in understanding the bio-psychosocial factors that impact individuals, families and support systems. Social workers are able to examine the complexity of a situation and empower clients to select an appropriate course of action to enhance the wellbeing of the person, community and/or society. Social workers play an integral role within the primary health care system focusing on preventing people from becoming ill or injured, managing chronic conditions, accessing social programs, treating acute and episodic illness, supporting individuals to take an active role in their own health care, and understanding the factors outside the immediate health system that influence individual and community health.

Roles and Responsibilities:

- Identify the root causes of issues and determine appropriate areas for prevention and intervention;
- Assess social problems by obtaining case history and background information;
- Contribute knowledge to the team related to family dynamics, family functioning and attitude toward others;
- Provide information regarding patient and caregiver's ability to interpret and understand the team's recommendations and care prescribed to the individual;
- Provide individual, family, caregiver and group counseling;
- Education related to health promotion and prevention of mental health problems;
- Assist patient and caregivers in navigating the health care system and aid in accessing necessary services;
- Develop, manage, and deliver programs alone or in collaboration with other professionals;
- Promote comprehensive and co-ordinated care through collaboration with other health care professionals.

For further information:

New Brunswick Association of Social Workers
PO 1533, Station 'A'
Fredericton NB E3B 5G2

Telephone: (506) 459-5595 or (877) 495-5595
Email: nbasw@nbasw-atsnb.ca
Website: http://www.nbasw-atsnb.ca

Canadian Association of Social Workers
383 Parkdale Avenue, Suite 402
Ottawa ON K1Y 4R4

Telephone: (613) 729-6668 or (855) 729-2279
Email: casw@casw-acts.ca
Website: http://www.casw-acts.ca

Appendix B: Family Health Team Co-ordinator Position Description

Family Health Team Co-ordinator

General Description:

The FHT co-ordinator will play an integral role in the care of the patients of FHTs throughout New Brunswick. He/she will assist the FHT in achieving its vision, mission, goals and objectives. The co-ordinator will serve as the liaison between the Primary Health Care Network and FHT. The co-ordinator will provide co-ordinating and administrative support and human resources management. The co-ordinator will also be responsible for ensuring improvement in patient access and quality of services.

Roles and Responsibilities:

The successful candidate will be responsible for the development, planning and implementation of the FHT and will work in close collaboration with medical and non-medical personnel who are part of the team.

The co-ordinator will be assigned to a FHT once the application has been approved and will provide support to the team as it moves through the stages of becoming operational. The co-ordinator will continue as a member of the team to provide co-ordinating and administrative support, human resources management and to ensure quality of services.

This will involve:

- Participation in the development and measurement of project indicators and outcomes;
- Identification of new service requirements and deficiencies in current services;
- Development of plans to address requirements;
- Participation in the sharing of work processes and resources between all team members (that best optimizes efficiencies and maximizes service delivery);
- Facilitation of collaborative approaches within the interdisciplinary teams to provide comprehensive primary health care;
- Management and resolution of human resource issues (conflict management, succession planning, recruitment and retention, training and development in PHC principles and data collection);
- Supporting mental health, population health and chronic disease prevention management practices within the team;
- Ensuring health promotion, disease and injury prevention, care of the medically complex patient and care of patients with chronic diseases is provided by the team;
- Promoting and facilitating improved co-ordination and integration with other health-care services including secondary, tertiary, and long-term care through specialty care linkages to primary health care;
- Ensuring patients are knowledgeable about accessing timely primary health-care services including afterhours arrangement, extended hours of service, accessing all members of the FHT.

Essential Qualifications:

- Bachelor's degree in nursing or a health science discipline with a minimum of five years experience in health care and/or administration;
- Knowledge of the New Brunswick health-care system is required;
- Computer skills in a Microsoft Windows environment.; must include Excel and skills in database development and management.

Asset Qualifications:

Preference may be given to candidates who demonstrate:

- Experience in supervising, leading and facilitating working groups.
- Experience in establishing priorities in collaboration with others in a complex regional healthcare environment.
- Experience in customer service including the development of performance outcomes.

Operational requirement:

The ability to work regular weekday hours, and variable hours as required.

Behavioral competencies:

Co-ordination, Effective Interactive Communication, Teamwork and Cooperation, Commitment.

Technical competencies:

Data-collection methods, Organizational change, Primary health-care delivery.

Appendix C: Accountability Framework for Family Health Teams

Accountability and FHTs

A high-performing health-care system requires a strong primary health-care foundation. An accountable, co-ordinated health-care system should promote and support a variety of health-care professionals in providing integrated, patient-centered health care and optimal care outcomes in a team setting. Such a system assures that health-care providers know the patient's condition and treatment plan, optimize the use of tests, procedures, referrals and patient education to promote efficient and effective care, co-ordinate their care plans, and are accountable through a system of self-regulation including measurement against pre-set benchmarks for care improvement.

A review of current peer-reviewed journal articles supports the notion that an accountable, co-ordinated system of care counters fragmentation, avoids adverse drug interactions, minimizes acute exacerbations of untreated or inappropriately treated illness, avoids excessive costs, promotes efficient care, and assures better quality outcomes. Data from foreign health care systems highlight the benefits of better integrated, more accessible, highly accountable and less expensive systems (Davis, 2008).

Core Values of New Brunswick's FHTs

- **Accessibility**
  Ensuring all New Brunswickers have timely access to primary health care at the right place and the right time, to progress towards and maintain an optimal level of health.
- **Efficiency**
  Achieving the desired results with the most cost-effective use of resources.
- **Effectiveness**
  The care/service, intervention, or action achieves the desired results.
- **Integration**
  Provide continuous care that is co-ordinated across providers, practices and the health-care system in general.
- **Patient-centered**
  Patients are an integral part of the care team through collaboration with health-care professionals in making clinical decisions. Teams will provide care that considers patients' cultural traditions and values, their family situations and their lifestyles.
- **Safety**
  Primary health care delivered by FHTs must be delivered in an environment that is safe for the patient and the health care provider.
- **Appropriateness**
  Provide care and/or service that is relevant to clinical needs, given the current best evidence.
- **Appropriately resourced**
  Teams are resourced according to the needs of community, as determined by a CHNA, which may include human resources, practice improvement, training, funding, and technology.

Indicators

An indicator is a measurement tool, which is rate based or defined as an event, that is used as a guide to monitor, evaluate and improve the quality of client care and services, clinical support services and organizational functions, in order to make continuous improvements (Accreditation Canada). It is now well recognized that measurement at various levels is integral to determining if a system, practice or individual is delivering quality health care.

Structure

Structure indicators describe the type and amount of resources allocated by an organization to deliver programs and services. Structure indicators relate to elements such as staffing, policy and procedure, equipment, supplies, and resources.

Structure indicators will be reported by FHTs within the first six months of operation. These indicators are highlighted in red in the Performance Measurement Framework.

Examples:
Interdisciplinary team established, extended hours or after hours arrangement formalized, patient registration, EMR uptake

Process or Operational

Process or operational indicators describe the delivery of health-care services – steps taken in caring for the patient and how resources are used to deliver a program or service. Process or operational indicators are more sensitive to differences in the quality of care and they are direct measures of quality. These indicators provide important information about performance at all levels within an organization.

Operational indicators will be reported by FHTs within the first year of operation and every other year following. These indicators can be found in the row titled "Operational level indicators (patient / provider)" of the framework

Examples:
Percentage of patients over 65 who received a flu shot, percentage of patient screened for high blood pressure

Outcome or System

Outcome or system indicators describe the results of health-care services – the impact or effect that care and treatment have had or the results of structure and process. Outcome or system indicators can be disease specific, focus on general health, client performance, or patient satisfaction.

System indicators will be reported on the third year of operation and every other year after (in conjunction with submission of operational indicators above). Note that some operational and system indicators overlap.

Examples:
Percentage of patients who know what their medications are for, test results or records are available when needed, patient satisfaction with FHT experience.

New Brunswick Primary Health Care Performance Measurement Framework								
Core Values								
	Access	Integration	Patient centered	Effectiveness	Efficiency	Safety	Appropriateness	Appropriate resources
Operational level indicators (patient / provider)	• General access • Extended hours • After hours arrangement	Interdisciplinary team established	• Enough time for discussion • Patient is involved in decision making	• Patients who feel they can manage or control their health condition(s) • Extent to which health professional helped manage their health condition • Diabetes patients who have achieved an A1C level of 7 percent or less	Use of the Emergency Room (ER)	Patients who know what their medications are for	• Flu shot given to persons 65+ • Chronic Disease Patients: Blood pressure measurement • Chronic Disease Patients: Blood sugar testing-diabetes patient • Chronic Disease Patients: Body weight measurement • Chronic Disease Patients: Cholesterol testing	• EMR uptake (%) • Patient Registration
System level indicators	• Patients who can get same day/next day appointments • After-hours arrangement	• Primary health-care provider helps to co-ordinate with other providers • Access to FHTs	Population who rate their primary health-care services an 8, 9 or 10 on a scale of zero to 10.	• Diabetes patients who have achieved an A1C level of 7 percent or less • Patients in the Obese Category	Rate of patients hospitalized for Ambulatory Care Sensitive Conditions (ACSC)	Patients who know what their medications are for	Population 65 and over receiving a flu shot	• Test results or records available at visit • Primary care providers with an EMR system
			Community Health Needs Assessment (focus on population health)					

Legend

Red Level Indicators Required by FHTs within six months

Operational Indicators Report findings within first year of FHT establishment (baseline data)

Operational/System Indicators Report all indicators (operational and system) every other year after year one

Summary of Indicators for Accountability Framework

Operational Level Indicators (Provider/Patient):

Six essential operational indicators have been established which must be collected within the first six months of the establishment of a FHT.

Baseline Indicators:

All baseline indicators must be reported within the first year of the establishment of FHT. Baseline data will be collected by the FHT Co-ordinator by means of a standardized patient survey and repeated every two years.

System indicators:

System indicators monitor overall effect of the primary health-care reform strategies. The data for all system indicators will be collected by the Primary Health Care Network and updated annually (based on data reporting cycle).

Structure Indicators (Required Elements)

Indicator # 1			
General Access (Required Element)			
Description	Number of days to "third next available" appointment		
Goal	Reduce wait times and increase access.		
Target/Benchmark	Decrease number of days to next available appointment by 20% with benchmark at 5 days		
Five days average method of calculation	Observe registration data or scheduler of all physicians and nurse practitioners (NPs) on the same day of the week. Count the number of days between a request for an appointment with a physician/NP and the third next available appointment for a new patient physical, routine exam or return visit exam. Report the average number of days for all physicians/NPs sampled in the designated time period and average for the team (CIHI, 2006; Horizon Health Network, 2013/14). **Note:** *Count by calendar days (e.g. include weekends) and days off. Data collection can be done manually or electronically.*		
Appointment obtained within _____ days	Checklist: Average number of days documented		
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Scheduler / Registration Data
Core Value Measured			
☒ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
This is the standard for measuring delay. It removes chance occurrences of available appointments (i.e. the first and second appointments are often due to cancellations) and gives you a more accurate picture of your FHT's handling of demand (CIHI, 2006; Horizon Health Network, 2013/14).			

Indicator # 2			
General Access: After-hours arrangement (Required Element)			
Description	FHT has an after-hours arrangement, when the office is closed, that increases access through an after-hours clinic, Telecare, Community Health Centre, etc.		
Goal	Reduce wait times and increase access		
Target/Benchmark	N/A		
Method of calculation	Checklist: FHTs have established an arrangement for patients when the office is closed		
Yes or no	Yes, if an arrangement is in place; No, if there is not		
Data collection responsibility	Family Health Team Co-ordinator	Source of information	FHT Checklist
Core Value Measured			
☒ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
Difficulties in accessing primary health care may be due to a variety of factors. The ability to obtain routine PHC services when needed is believed to be important in maintaining health, preventing health emergencies and preventing inappropriate use of services (e.g. use of hospital emergency rooms for non-emergencies). Having an after-hours arrangement in place allows patients to access PHC services when they need it. A low percentage of the population experiencing difficulty assessing routine PHC care for self, a family member or dependent is interpreted as a positive result.			

Indicator # 3			
General Access: Extended hours (Required Element)			
Description:	FHT increases hours the office is open (i.e. Provides night time and/or weekend hours)		
Goal:	Reduce wait times and increase access		
Target/Benchmark	3 to 5 sessions of extended hours (weekday evenings and/or weekends) based on number of group physicians.		
Method of calculation	Checklist documentation		
Yes or no			
Data collection responsibility	Family Health Team Co-ordinator	Source of information	FHT Checklist
Core Value Measured			
☒ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
Difficulties in accessing primary health care may be due to a variety of factors. The ability to obtain routine PHC services when needed is believed to be important in maintaining health, preventing health emergencies and preventing inappropriate use of services (e.g. use of hospital emergency rooms for non-emergencies). Offering care on evenings or weekends allows patients who have difficulty accessing PHC services during the day more flexible options. A low percentage of the population experiencing difficulty assessing routine PHC care for self, a family member or dependent is interpreted as a positive result.			

Indicator # 4			
Interdisciplinary Team Established (Required Element)			
Description:	Application process is complete and the FHT is established		
Goal:	Provide collaborative, comprehensive, accessible, coordinate health care services to patients in a team setting		
Target/Benchmark			
Method of calculation	Team is established – box checked off on checklist form		
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Completed FHT Application
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☒ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
"Timely access to family and community care through primary health care reform is a high priority for all jurisdictions. Significant progress is underway in all jurisdictions to meet the objective of 50% of Canadians having 24/7 access to multidisciplinary teams by 2011. Building on this progress, First Ministers agree to establish a best practices network to share information and find solutions to barriers to progress in primary health care reform such as scope of practice. First Ministers agree to regularly report on progress." *— 10-Year Plan to Strengthen Health Care*			

Indicator # 5			
EMR Adoption (Required Element)			
Description:	It is required that each FHT invest in an EMR system (or shows proof that the team is planning to purchase an EMR, with timeline included)		
Goal:	Every FHT will have a EMR system		
Target/Benchmark			
Method of calculation	Checklist: The FHT has an EMR in place		
Yes or no			
Data collection responsibility	Family Health Team Co-ordinator	Source of information	FHT Checklist (provided)

Core Value Measured	
☐ Accessibility	☐ Efficiency
☐ Integration	☐ Safety
☐ Patient Centred	☐ Appropriateness
☐ Effectiveness	☒ Appropriate Resources

Rationale and Interpretation

One of the fundamental reasons for implementing EMRs is the potential for improved health outcomes of patients (e.g. patient safety, wait time reduction, management of chronic diseases, etc.). Other benefits of information technology that support the improvement of primary care services and access include better monitoring and measuring of outcomes, improved safety, accuracy and effectiveness in prescribing tests and medications, better availability and faster retrieval of individual patient clinical information, accurate and timely exchange of patient information among healthcare providers, development and delivery of prevention strategies and educational materials to patients, and reduced overall costs. A high rate of FHTs with EMRs is a positive result.

Indicator # 6			
Patient Registration (Required Element)			
Description:	Family physicians and nurse practitioners must have a minimum number of patients on the patient registration list and will add unattached patients to the panel if benchmark is not met		
Goal:	To reduce, and eventually eliminate, the number of unattached patients in the province		
Target/Benchmark	Based on established minimum practice guidelines		
Method of calculation			
Benchmark met (yes or no)			
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Patient volume from office, FHT policies

Core Value Measured	
☐ Accessibility	☐ Efficiency
☐ Integration	☐ Safety
☐ Patient Centred	☐ Appropriateness
☐ Effectiveness	☒ Appropriate Resources

Rationale and Interpretation

A regular care provider is the primary care provider that a patient identifies as 'theirs'. Access to a doctor or NP has been identified as a key performance indicator to improving health as it enables a relationship that supports continuity and comprehensive care. Continuity of care and principal responsibility of a regular care provider is associated with increased quality of care, patient satisfaction and effective patient management. A high percentage of the population with a regular care provider is interpreted as a positive result (CIHI, 2006).

Operational Indicators (Provider/Patient)

Indicator # 1			
Patient Given Enough Time for Discussion			
Description:	Patient reported that their FHT "always" or "usually" was given enough time to discuss their feelings, fears, and concerns about their health		
Goal:	To provide patient centered care where patients are an integral part of their care plan		
Target/Benchmark	Increase by 10%, benchmark 85%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Survey response: Always or never	Denominator	Total responses
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Patient survey
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☒ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
FHTs often care for patients with chronic conditions who require complex interventions tailored to their individual needs. If patients are provided with sufficient time in their visit, they may accurately and thoroughly discuss their medical history and symptoms and share questions and concerns about medical decisions or procedures, which may pre-empt ineffective treatment or errors. A high rate for this indicator can be interpreted as a positive result.			

Indicator # 2			
Patient Involved in Decision-making			
Description:	Patient reports that their FHT "always" or "usually" involved them in decisions about their health care		
Goal:	To involve patients in making decisions about their care		
Target/Benchmark	Increase by 10%, benchmark 85%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	"Always" or "Usually" involved in decisions	Denominator	Total number of survey respondents
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Patient survey
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☒ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
Participation in clinical decision-making reflects responsiveness of FHT providers to the needs of their practice population and involvement in care planning. A patient's health status may be influenced by their perception of being a full participant in clinical decision-making. CIHI found that agreements between provider and patient were found to be a key factor influencing health outcomes. A high rate of primary health care patients reporting involvement in decision-making is interpreted as a positive result.			

Indicator # 3			
Personal Management and Control			
Description:	Percentage of patients who feel they can manage or control their health condition(s)		
Goal:	Patients feel they can easily manage and control their health condition(s)		
Target/Benchmark	Increase by 10%, benchmark 50%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Patients who feel they can control their health condition(s) (responded "strongly agree" or "agree"	Denominator	Number of total survey respondents
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Patient survey (NBHC and CCHS surveys for comparison)
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☒ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
This indicator will provide an estimate of whether the FHT is offering the necessary support to patients. The Canadian Task Force on Preventative Health Care suggests that counselling by PHC providers may produce long-term behavioural changes for a number of health risk behaviours and enables patients to better manage and control their health.			

Indicator # 4			
Personal Management and Control (Self-reported Health Status)			
Description:	Extent to which health professional helped patient manage their health condition		
Goal:	Patients feel that the health professional in the FHT helped manage and control their health condition(s) a great deal or somewhat.		
Target/Benchmark	Increase by 10%, benchmark 90%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Patients who felt their health professional helped them a great deal or somewhat.	Denominator	Number of total survey respondents
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Patient survey
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☒ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
This indicator will provide an estimate of whether the FHT are offering the necessary support to patients. The Canadian Task Force on Preventative Health Care suggests that counselling by PHC providers may produce long-term behavioural changes for a number of health risk behaviours and enables patients to better manage and control their health.			

Indicator # 5			
Diabetes Management			
Description:	Percent of diabetes patients who have achieved an A1C level of 7 percent or less		
Goal:	Increase the number of patients achieving targeted A1C levels		
Target/Benchmark	Increase by 5%, benchmark 60%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Number of patients with diabetes with A1Cs above 7 percent	Denominator	A1C levels of all patients with diabetes
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Diabetes Registry
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☒ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
Preventative health services and health promotion have the potential to influence the health behaviours of individuals. The Canadian Task Force for Preventative Health Services has recommended that PHC providers provide screening and advice on common health risks, such as blood sugar levels. This indicator measures the comprehensiveness of services offered by the team, and is an important factor in the continuity of care and patient outcomes. A higher rate for this indicator can be interpreted as a positive result.			

Indicator # 6			
Emergency Department Use			
Description:	Percentage of FHT patients who visited a hospital emergency department in the past year		
Goal:	Decrease unnecessary visits to the emergency department		
Target/Benchmark	Increase by 5%, benchmark 30%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Visits to the ER within the current year	Denominator	Total number of patients in practice
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Medicare billing or Patient Survey
Core Value Measured			
☐ Accessibility		☒ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
The ability to obtain routine Primary Health Care Services, such as that from a FHT, when needed is believed to be important in maintaining health, preventing health emergencies and preventing inappropriate use of services, such as using hospital emergency rooms for non-emergencies. A low percentage of the population visiting a hospital emergency department when not necessary is a positive result.			

Indicator # 7			
Medication Management and Control			
Description:	Patients understand what their medications are for		
Goal:	All patients understand what their medications are for		
Target/Benchmark	Increase by 5%, benchmark 50%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Patients who "strongly agree" that they know what each of their prescribed medications are for	Denominator	All survey respondents
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Patient survey
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☒ Safety	
☐ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
Patients' knowledge of the proper use of medications and their associated side effects enhances compliance. The advent of more complex pharmaceutical care intensifies the need for health provider review and discussions and patients to minimize risks and help patients adhere to medication regimens. A high rate for this indicator can be interpreted as a positive result.			

Indicator # 8			
Influenza Immunization			
Description:	Patients, aged 65 years and over, who received an influenza immunization within the past 12 months		
Goal:	Reduce incidence of influenza in persons 65+		
Target/Benchmark	Increase by 5%, benchmark 80%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Patients 65+ who received an influenza immunization within past 12 months	Denominator	Total number of patients 65+ within the past 12 months
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Patient survey
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☒ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
The influence virus is responsible for substantial morbidity and mortality in Canada, that may, in part, be preventable through immunization programs. People aged 65 years and over are at high risk for influenza-related complications; thus, it is recommended that they receive a vaccine every year. For elderly people, influenza and pneumococcal vaccines are reported as more cost-effective than all over preventative, screening and treatment interventions that have been studied. A high rate for this indicator can be interpreted as a positive result.			

Indicator # 9			
Chronic Disease Screening – Blood Pressure Measure			
Description:	Patients who had their blood pressure measured within the past 12 months Screening for chronic disease through the measurement of a patient's blood pressure to assess modifiable risk factors		
Goal:	Prevent and/or manage chronic disease(s)		
Target/Benchmark	Increase by 5%, benchmark 95%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Patients who have had their blood pressure measured by their FHT within the past 12 months	Denominator	Total number of patients in the past 12 months
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Patient survey
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☒ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
Regular blood pressure measurement helps identify individuals with hypertension, a major cause of a heart attack or stroke. The Canadian Task Force for Preventative Health Services has recommended that PHC providers provide screening and advice on common health risks, such as high blood pressure. This indicator measures the comprehensiveness of services offered by the team, and is an important factor in the continuity of care and patient outcomes. Despite advances in the management of hypertension there remains a gap at the front-end of disease management, that is, in the detection and diagnosis of hypertension. Many patients are unaware they have hypertension (17 percent was reported from the 2009 Canadian Health Measures Survey); even through numerous studies have proven the benefit of lowering blood pressure. Preventative health services and health promotion have the potential to influence the health behaviours of individuals. A high rate for this indicator can be interpreted as a positive result.			

Indicator # 10			
Chronic Disease Screening: Blood Sugar Testing			
Description:	Glycemic testing to identify patients achieving an A1C level of 7 percent or less		
Goal:	Increase the number of patients being tested		
Target/Benchmark	Increase by 5%, benchmark 90%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Number of patients who had an A1C test	Denominator	All patients with diabetes
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Patient survey or EMR
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☒ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
Preventative health services and health promotion have the potential to influence the health behaviours of individuals. The Canadian Task Force for Preventative Health Services has recommended that PHC providers provide screening and advice on common health risks, such as blood sugar levels. This indicator measures the comprehensiveness of services offered by the team, and is an important factor in the continuity of care and patient outcomes.			

Indicator # 11			
Chronic Disease Screening: Body Weight Measurement			
Description:	Patients with a chronic disease who have had a body weight measurement in the past 12 months		
Goal:	Decrease the prevalence of patients who are obese		
Target/Benchmark	Increase by 5%, benchmark 80%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Number of patients who were weighed	Denominator	Patients having at least 1 chronic disease
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Patient survey or EMR
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☒ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
Obesity is a recognized health risk that may lead to an increased likelihood of certain diseases such as hypertension, stroke, Type 2 diabetes, coronary heart disease, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems and certain cancers. In addition, being overweight or obese is associated with increased overall morbidity and mortality. The Canadian Task Force for Preventative Health Services has recommended that PHC providers provide screening and advice on common health risks. A review of counseling recommendations in PHC supports the relevance of counseling for high-risk behaviours such as unhealthy dietary patterns and physical inactivity - which can result in obesity. This indicator measures the comprehensiveness of services offered by the team, and is an important factor in the continuity of care and patient outcomes. A low rate for this indicator can be interpreted as a positive result.			

Indicator # 12			
Chronic Disease Screening: Cholesterol testing			
Description:	Patients with at least one chronic condition who had their cholesterol measured within the past 12 months		
Goal:	Improve management of cardiovascular disease		
Target/Benchmark	Increase by 5%, benchmark 85%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Number of patients who had their cholesterol measured in the past 12 months	Denominator	Total number of survey respondents
Data collection responsibility	Family Health Team Co-ordinator	Source of information	Patient survey or EMR
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☒ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
Evaluating and assessing cholesterol, a modifiable risk factor, can help to prevent and/or diagnose hypertension, diabetes, dyslipidemia, coronary heart disease and others. This indicator measures the comprehensiveness of services offered by the team, and is an important factor in the continuity of care and patient outcomes. A high rate for this indicator can be interpreted as a positive result.			

System Level Indicators

Indicator # 1			
General Access			
Description:	Percent of patients who can get same day/next day appointments.		
Goal:	Reduce wait times and improve access		
Target/Benchmark	Increase by 5%, benchmark 45% for same day/next day		
Method of calculation	Numerator (number of those 18 and over who responded that they were able to receive an appointment with primary health care provider within same day/next day/ denominator (total number of respondents who saw a primary health care provider)		
Data collection responsibility	Family Health Team Co-ordinator	Source of information	NBHC Primary Health Care Survey or National Surveys
Core Value Measured			
☒ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
This is the standard for measuring delay. It removes chance occurrences of available appointments (i.e. the first and second appointments are often due to cancellations) and gives a more accurate picture of the FHT's handling of demand (CIHI, 2006; Horizon Health Network, 2013/14).			

Indicator # 2			
Advanced Access: After-hours Arrangement			
Description:	FHT has an after-hours arrangement, when the office is closed, that increases access through an after-hours clinic, Telecare, Community Health Centre, etc.		
Goal:	Reduce wait times and increase access		
Target/Benchmark	Increase by 5%, benchmark 50%		
Method of calculation	Numerator (number of those 18 and over who responded that they were able to receive an appointment with primary care provider within same day/next day/ denominator (total number of respondents who saw a primary health care provider)		
Data collection responsibility	Family Health Team Co-ordinator	Source of information	NBHC Primary Health Care Survey or National Surveys
Core Value Measured			
☒ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
Difficulties in accessing primary health care may be due to a variety of factors. The ability to obtain routine PHC services when needed is believed to be important in maintaining health, preventing health emergencies and preventing inappropriate use of services (e.g. use of hospital emergency rooms for non-emergencies). Having an after-hours arrangement in place allows patients to access PHC services when they need it. A low percentage of the population experiencing difficulty assessing routine PHC care for self, a family member or dependent is interpreted as a positive result.			

Indicator # 3			
Access to FHT			
Description:	Population with access to family health team		
Goal:	Provide collaborative, comprehensive, accessible, coordinated health care services to patients in a team setting		
Target/Benchmark	Increase by 5%, benchmark 50%		
Method of calculation	Primary health care team is defined as : having a personal family doctor AND a nurse is regularly involved in health care OR a nurse practitioner is regularly involved in health care OR other health professionals work in the same office as the personal family doctor		
Data collection responsibility	Family Health Team Co-ordinator	Source of information	NBHC Primary Health Care Survey or National Surveys
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☒ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
"Timely access to family and community care through primary health care reform is a high priority for all jurisdictions. Significant progress is underway in all jurisdictions to meet the objective of 50 percent of Canadians having 24/7 access to multidisciplinary teams by 2011. Building on this progress, First Ministers agree to establish a best practices network to share information and find solutions to barriers to progress in primary health care reform such as scope of practice. First Ministers agree to regularly report on progress." *— 10-Year Plan to Strengthen Health Care*			

Indicator # 4			
Team Helps to Coordinate with Other Providers			
Description:	Percentage who reported that their FHT "always" or "usually" helped them coordinate the care from other healthcare providers and places when they needed it		
Goal:	Improve coordination and continuity, resulting in better health of patients		
Target/Benchmark	Increase by 5%, benchmark 75%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	"Always" or "usually" response to coordination with other providers question on survey	Denominator	Number of total survey participants
Data collection responsibility	Family Health Team Co-ordinator	Source of information	NBHC Primary Health Care Survey or National Surveys
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☒ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
Co-ordination of services is one of the main elements of FHTs. Co-ordination between providers and institutions enables providers to achieve informational and management continuity of patient care. A high rate of FHTs with these processes in place is interpreted as a positive result..			

Indicator # 5			
Percentage of patients rating satisfaction with PHC experience at 8, 9, 10			
Description:	Percentage of population who rate their primary health care services an 8, 9 or 10 on a scale of zero to 10.		
Goal:	Patients are satisfied with the care they are experiencing with their primary care provider services		
Target/Benchmark	Increase by 5%, benchmark 85%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Number of patients who rate their primary health care services an 8, 9, or 10.	Denominator	# of total survey respondents who received primary health care services
Data collection responsibility	Family Health Team Co-ordinator	Source of information	NBHC Primary Health Care Survey or National Surveys
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☒ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
This indicator measures the satisfaction of patients with the range of primary health-care services available/experienced. In conjunction with other indicators that track changing characteristics of the PHC system, this indicator can assess from a patient perspective whether access to comprehensive PHC services is changing. FHTs can provide specialized services that fit the health requirement of their defined population and include providers with skill sets that reflect the needs of the community. A high rate of patients reporting that services meet their needs is interpreted as a positive result.			

Indicator # 6			
Diabetes Management			
Description:	Percentage of diabetes patients who have achieved an A1C level of 7 % or less		
Goal:	Increase the number of patients achieving targeted A1C levels		
Target/Benchmark	Increase by 5%, benchmark 60%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Number of patients with diabetes with A1Cs above 7 percent	Denominator	A1C levels of all patients with diabetes
Data collection responsibility	Family Health Team Co-ordinator, DH	Source of information	Diabetes Registry
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☒ Effectiveness		☐ Appropriate Resources	
Rationale and Interpretation			
Preventative health services and health promotion have the potential to influence the health behaviours of individuals. The Canadian Task Force for Preventative Health Services has recommended that PHC providers provide screening and advice on common health risks, such as blood sugar levels. This indicator measures the comprehensiveness of services offered by the team, and is an important factor in the continuity of care and patient outcomes. A higher rate for this indicator can be interpreted as a positive result.			

Indicator # 7			
Percentage of Patients in the Obese Category			
Description:	Measuring the percentage of patients who are obese (have a Body Mass Index (BMI) of 30.0* or more) (as defined by Statistics Canada)		
Goal:	Decrease the prevalence of patients who are obese		
Target/Benchmark	Increase by 5%, benchmark 20%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Number of patients in the obese range (BMI over 30.0)	Denominator	Number of total survey participants
Data collection responsibility	Family Health Team Co-ordinator	Source of information	CCHS (Statistics Canada) or NBHC Primary Health Care Survey

Core Value Measured	
☐ Accessibility	☐ Efficiency
☐ Integration	☐ Safety
☒ Patient Centred	☐ Appropriateness
☐ Effectiveness	☐ Appropriate Resources

Rationale and Interpretation

Obesity is a recognized health risk that may lead to an increased likelihood of certain diseases such as hypertension, stroke, Type 2 diabetes, coronary heart disease, gallbladder disease, osteoarthritis, sleep apnea, respiratory problems and certain cancers. In addition, being overweight or obese is associated with increased overall morbidity and mortality. The Canadian Task Force for Preventative Health Services has recommended that PHC providers provide screening and advice on common health risks. A review of counseling recommendations in PHC supports the relevance of counseling for high-risk behaviours such as unhealthy dietary patterns and physical inactivity - which can result in obesity. This indicator measures the comprehensiveness of services offered by the team, and is an important factor in the continuity of care and patient outcomes. A low rate for this indicator can be interpreted as a positive result.

Indicator # 8			
Hospitalization for Ambulatory Care Sensitive Condition (ACSC)			
Description:	Age-standardized acute care hospitalization for conditions where appropriate ambulatory care prevents or reduces the need for admission to hospital. **ACSC definition:** *ACSC selected conditions include grand mal status and other epileptic convulsions, chronic obstructive pulmonary disease, asthma, congestive heart failure, hypertension, angina, and diabetes* (CIHI, 2006)		
Goal:	Reduce rate of patients hospitalized for ACSC		
Target/Benchmark	Decrease by 5%, benchmark 300/100 000		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Total number of hospital admissions for ACSC in the past 12 months	Denominator	Total mid-year population 75 years and under per 100,000 (age adjusted)
Data collection responsibility	Family Health Team Co-ordinator, DH	Source of information	DAD (Discharge Abstract Database)

Core Value Measured	
☐ Accessibility	☒ Efficiency
☐ Integration	☐ Safety
☐ Patient Centred	☐ Appropriateness
☐ Effectiveness	☐ Appropriate Resources

Rationale and Interpretation

ACSCs include long-term health conditions, which can often be managed with timely and effective treatment in the community. ACSCs include chronic conditions such as diabetes, asthma, hypertension and others. Optimizing management and treatment of these conditions in the community, including the PHC setting, can potentially contribute to both improved client/patient health outcomes and more efficient resource utilization. Variations over time, and differences between regions, should be examined to determine the extent to which they are attributable to the accessibility and quality of community-based care, hospital admitting practices, or prevalence and acuity of these chronic health conditions. A low rate for this indicator can be interpreted as a positive result.

Indicator # 9			
Medication Management and Control			
Description:	Patients understand what their medications are for		
Goal:	All patients understand what their medications are for		
Target/Benchmark	Increase by 5%, benchmark 50%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Patients who "strongly agree" that they know what each of their prescribed medications are for. Patients who "completely understand" or "understand" what their medications are for.	Denominator	All survey respondents
Data collection responsibility	Family Health Team Co-ordinator, DH	Source of information	NBHC Primary Health Care Survey

Core Value Measured	
☐ Accessibility	☐ Efficiency
☐ Integration	☒ Safety
☐ Patient Centred	☐ Appropriateness
☐ Effectiveness	☐ Appropriate Resources

Rationale and Interpretation

Patients' knowledge of the proper use of medications and their associated side effects enhances compliance. The advent of more complex pharmaceutical care intensifies the need for health provider review and discussions and patients to minimize risks and help patients adhere to medication regimens. A high rate for this indicator can be interpreted as a positive result.

Indicator # 10			
Influenza Immunization			
Description:	Patients, aged 65 years and over, who received an influenza immunization within the past 12 months		
Goal:	Reduce incidence of influenza in persons 65+		
Target/Benchmark	Increase by 5%, benchmark 80%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Patients 65+ who received an influenza immunization within past 12 months.	Denominator	Total number of patients 65+ within the past 12 months.
Data collection responsibility	Family Health Team Co-ordinator	Source of information	NBHC Primary Health Care Survey or CCHS (Statistics Canada)

Core Value Measured	
☐ Accessibility	☐ Efficiency
☐ Integration	☐ Safety
☐ Patient Centred	☒ Appropriateness
☐ Effectiveness	☐ Appropriate Resources

Rationale and Interpretation

The influence virus is responsible for substantial morbidity and mortality in Canada, that may, in part, be preventable through immunization programs. People aged 65 years and over are at high risk for influenza-related complications; thus, it is recommended that they receive a vaccine every year. For elderly people, influenza and pneumococcal vaccines are reported as more cost-effective than all over preventative, screening and treatment interventions that have been studied. A high rate for this indicator can be interpreted as a positive result.

Indicator # 11			
Availability of Test Results			
Description:	Measuring how often results or medical records are available to the team at the time of the patient's visit		
Goal:	Test results and records are available when needed		
Target/Benchmark	Increase by 5%, benchmark 95%		
Method of calculation	(Numerator / Denominator) X 100 =		
Numerator	Test results or medical records were available at time of visit	Denominator	All survey respondents
Data collection responsibility	Family Health Team Co-ordinator	Source of information	NBHC Primary Health Care Survey or National Survey
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☒ Appropriate Resources	
Rationale and Interpretation			
Adequate record keeping facilitates good care delivered to FHT patients.			

Indicator # 12			
EMR Adoption			
Description:	It is required that each FHT invest in an EMR system (or shows proof that the team is planning to purchase an EMR, with timeline included)		
Goal:	Increase number of primary care providers with an EMR system		
Target/Benchmark	Increase by 5%, benchmark 50%		
Method of calculation	(Numerator / Denominator) X 100 =		
Data collection responsibility	Family Health Team Co-ordinator	Source of information	National Survey, NB Medical Society
Core Value Measured			
☐ Accessibility		☐ Efficiency	
☐ Integration		☐ Safety	
☐ Patient Centred		☐ Appropriateness	
☐ Effectiveness		☒ Appropriate Resources	
Rationale and Interpretation			
One of the fundamental reasons for implementing Electronic Medical Records (EMRs) is the potential for improved health outcomes of patients (e.g. patient safety, wait time reduction, management of chronic diseases, etc.). Other benefits of information technology that support the improvement of primary care services and access include better monitoring and measuring of outcomes, improved safety, accuracy and effectiveness in prescribing tests and medications, better availability and faster retrieval of individual patient clinical information, accurate and timely exchange of patient information among healthcare providers, development and delivery of prevention strategies and educational materials to patients, and reduced overall costs. A high rate of FHTs with EMRs is a positive result.			

Appendix D: References (Endnotes)

Section 1: Background

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Section 2: Family Health Teams

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Appendix E: Application Process

Step 1: Operational Guide for Family Health Teams

Familiarize yourself with the Guide and relevant reference material

Step 2: FHT Letter of Interest Form

Complete and submit your Letter of Interest Form to Primary Health Care Steering Committee for approval: primaryhealth.santeprimaire@gnb.ca

Step 3: FHT Application Form

Complete and submit your FHT Application Form to Primary Health Care Steering Committee: primaryhealth.santeprimaire@gnb.ca

Letter of Interest Form

To: ***Primary Health Care Unit***
Department of Health
PO 5100
Fredericton NB E3B 5G8

Submission Date: _____

We are interested in a Family Health Team for (name of community): _____

Following is a brief overview of our vision for our proposed FHT: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Name of Primary Contact	Email	Telephone

Submit completed form to: primaryhealth.santeprimaire@gnb.ca

IMPORTANT: Prior to completing this documentation, you should have submitted your *Letter of Interest Form* to the Primary Health Care Branch and received confirmation to proceed with the application process.

INSTRUCTIONS: Answer each of the questions accurately, concisely and completely. Applications will be evaluated according the information provided.

CONTACT: If you have questions about this application or experience technical difficulty with the form, please email primaryhealth.santeprimaire@gnb.ca or call 506-444-4174 for assistance.

DISCLAIMER: It is the applicant's responsibility to ensure that the information provided is up-to-date and correct to the best knowledge of the applicant. By submitting the application, applicants acknowledge that this is not a procurement/tender and the determination of the successful candidates shall be made at the sole and absolute discretion of the Department of Health. In reviewing the application, the Department of Health reserves the right to discuss and disclose the contents of such applications within the broader public sector and the applicants by submitting applications, expressly consent to such disclosure.

Family Health Team Application Form

1. Business Contact Information

Name of Primary Contact (title, first name, last name)

Mailing Address | Postal Code

Telephone | Alternate Telephone | Fax | Email

2. FHT Location Information

Name of proposed FHT: _____

3. **Service Gaps:** Based on the Community Health Needs Assessment completed in your community, describe any gaps in primary health care services (i.e. primary health care services that are NOT available) and/or any difficulties regarding patient access to primary health care services in your community. Also describe how your FHT intends to address these gaps.

Gaps in Primary Health Care Services	How FHT will address these gaps
Note (Drop in community-specific identified gaps/needs)	
Additional details: If there are other relevant community or service area characteristics, provide details:	

4. **Team Composition**

Proposed FHT members: Indicate the team members and whether or not they will be co-located.

Note: This question is intended to provide an idea of the composition of your FHT. It is not a requirement the resources are secured at this point, nor will approval of this application automatically imply approval of your proposed human resources. Successful applicants will have access to resources to guide them through the establishment of their provider team.

***Working definition of FTE: 1,950 hours/year**

Current Positions *Title/Professional designation*	FTE (hrs/yr)	Proposed Position *Title/Professional designation*	FTE (hrs/yr)	Proposed Functions	Co-located	
					Yes	*No

5. **FHT Location:** Has your group identified a location for the FHT?

☐ *Yes (Provide location[s] details)*

☐ *No (If not co-located, provide reason along with number of off-site locations):*

6. **Legal Structure:** Check the structure you intend to operate under and provide associated details below:

☐ *Not-for profit corporation* ☐ *Professional corporation* ☐ *Other*

Check to confirm your commitment to:

☐ *Utilize the provincial electronic medical record within one year of creation of the FHT.*

☐ *Provide extended hours of service*

☐ *Provide same-day next day scheduling*

☐ *Accept orphan patients*

☐ *Support team members working to full scope of practice*

☐ *Periodic timely evaluation/performance review of the FHT*

Signature: Primary Contact/Authorized Representative

Appendix F: Criteria for Family Health Team Application Approval

Applications will be evaluated on, but not limited to, the following criteria:

1. **Alignment with FHT model goals and objectives:**
   Evidence that the application is in line with goals and objectives of the FHT model

2. **Mandatory Requirements:**
   Meets the mandatory requirements relating to:
   - Completed Community Health Needs Assessment;
   - Team composition;
   - Administrative and legal structure;
   - Hours of operation and after-hours service;
   - Capacity to accept patients from Patient Connect NB;
   - Electronic Medical Record.

3. **Community Needs:**
   Demonstrated awareness of the community's primary health-care needs, services, assets and potential partners services within the health zone.

4. **Service Strategy Alignment:**
   Evidence that proposed strategies and programs to address service gaps are focused on meeting the community's unmet primary health-care needs.

5. **Community Linkages/Partnerships:**
   Evidence of established or potential linkages/partnerships with other community and health services to provide co-ordinated service delivery to support service integration, including linkages with the health zone.

6. **Operational Readiness:**
   Time required to become operational. (i.e. Access to facility infrastructure, human resources commitments)

7. **Critical Success Factors and/or Barriers:**
   Assessment of factors critical to the success of proposed FHT and the identification of barriers to implementation and the associated mitigation strategies.

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