NHSRU | Nursing Health Services Research Unit

# An Evaluation of Communication Practices in Ontario Family Health Teams (FHT)

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## EXECUTIVE SUMMARY

The Family Health Team (FHT) initiative is providing care to more than 1.7 million Ontarians, including 180,000 patients who did not previously have a family physician Furthermore, early Ministry estimates suggest that physicians in these new settings will be able to see "up to 52%" more patients a day than physicians working in traditional practice settings.

The Ministry of Health and Long Term Care (MOHLTC) has set a target of implementing an additional 50 family health teams and 25 nurse practitioner-led health care clinics, over the next four years. This will bring the total FHTs to 200 with the hopes of facilitating around-the-clock care for Ontarians and reducing the strain on the already over burdened Emergency departments around the province.

This study is preliminary in nature, and will investigate participant's experiences working in FHTs, as well as investigate collaboration, role conflict and ambiguity. Although this study is largely exploratory the researchers hope to examine the data for trends linking collaborative practices to wait times, job satisfaction and stress.

Nurses interviewees were asked to provide recommendations to improve the overall efficiency of the Family Health Team initiative. The full list of suggestions included:

1. Improve collaboration and communication within the FHT to enhance inter –disciplinary practice (e.g., teach skills and strategies to implement).
2. Ensure healthcare professionals are working to their full professional capacity
3. Encourage physicians to put forward referrals to other healthcare professionals (e.g., nurse practitioners, dietician etc) to collaboratively manage complex patients, as it is not always necessary for them to see a physician.
4. Implement clinical meetings with all FHT providers to enable conversation about patient care.
5. Encourage physicians to advise patients that they don't always need to be seen by the physician.
6. Both hire and speed up the hiring process of more RNs, NPs, Pharmacists and Psychiatrists.
7. Develop chronic disease self management programs.
8. Educate the community to what a FHT does and advertise the concept to increase awareness (e.g., community newsletter).

9. Review the structure of FHTs. Physicians who are hiring staff are also on the board governing the FHT which can create a potential conflict of interest and compromise dynamic of the FHT.
10. Introduce clinical guidelines which are easy to implement for conditions such as asthma and diabetes. Model them on the hypertension initiative introduced by Heart and Stroke.

## SUMMARY

Reducing ER wait times and improving access to family health care for all Ontarians have been expressed as the Government of Ontario's top two health care priorities over the next 4 years (2008-2012) (Ontario Ministry of Health and Long-Term Care 2008). As a direct response to these identified priorities the Ministry of Health and Long Term Care has set a target of implementing an additional 50 family health teams (FHT) and 25 NP led health care clinics, over the next four years. This will bring the total FHTs to 200 with the hopes of facilitating around-the-clock care for Ontarians and reducing the strain on the already over burdened Emergency departments around the province.

FHTs are interdisciplinary care teams designed to improve the delivery of primary health care, and help us move away from the traditional model of uniprofessional physician care (Meuser, Bean et al. 2006). The FHT model of care is very similar to that of the Community Health Centres (CHCs) which are non-profit, community governed organizations that provide primary health care, health promotion and community development services, using interdisciplinary teams of health providers. Much like the FHT these teams include physicians, nurse practitioners, dieticians, health promoters, and counselors. CHCs were designed to target the needs of a specific community population and provide a targeted range of services such as health promotion and illness prevention services which provide a holistic approach to healthcare by addressing and raising awareness of the broader social determinants of health such as employment, education, environment, isolation, social exclusion and poverty. CHCs date back to the 1920s with approximately 300 across Canada and 54 in the province of Ontario as of 2006 (Ontario Ministry of Health and Long-Term Care 2007). The two main differences between CHCs and FHTs are compensation structure and governance. CHC teams including physicians receive salaries and benefits in contrast to the traditional fee-for-service models, and are governed by a community elected board of directors comprised of clients, community leaders, and health and social service providers (refs CHCs & MOH).

Building on the CHC's model of care the FHT initiative has the potential to significantly impact the top 2 healthcare priorities by increasing access to primary care for patients across Ontario. Early Ministry estimates suggest that physicians in these new settings will be able to see "up to 52%" more patients a day than physicians working in traditional practice settings, this does not take into account the ability of nurse practitioners to provide primary health care which could see this number increase. FHTs are already providing care to more than 1.7 million Ontarians,

including 180,000 patients who did not previously have a family physician (Ontario Ministry of Health and Long-Term Care 2008). Consequently this initiative should enable patients should be able to access health care more readily in the community, which has been shown to decrease the number of emergency room visits for people suffering from chronic diseases (ICES, 2008) hence reducing ER wait times and fulfilling both of the MOHLTC's top health care priorities.

To work at maximal capacity, an inter-disciplinary/collaborative approach to patient care is heavily reliant on strong communication skills, respect for each other's disciplines, and an understanding of the scope of each collaborator's practice. Studies have shown that teams that work well together are more effective and more innovative, have lower levels of stress and report greater personal and professional satisfaction (Curran 2004; D'amour and Oandasan 2005). Furthermore, it has been reported that client outcomes and satisfaction with the care received improve with collaboration (Corser 1998; Hojat, Fields et al. 1999; Wiggins 2008), which is particularly important given the current pressure from the public to improve the quality of care and patient outcomes (Gittell, Fairfield et al. 2000). A study by O'Brien-Pallas et al. (O'Brien-Pallas, Hiroz et al. 2005) has even suggested that improved relationships between nurses and physicians can be associated with improved physical health of nursing staff.

While studies have indicated negative employee satisfaction and patient outcomes as a result of inefficient or poor collaborative practices, research has also shown that these practices can improve with educational interventions such as group training, continuing professional development programs, educational interventions involving self-instructional guides and facilitated small group discussions (Bailey, Jones et al. 2006; Curran, Sargeant et al. 2007; Coleman, Roberts et al. 2008).

Despite an overwhelming body of evidence demonstrating the benefits of effective inter-professional collaboration in health care teams, and additional studies that show collaborative practices can be significantly improved with education, it is unclear whether supportive and positive collaborative practices have been embraced by Ontario's new FHTs. While the FHT initiative is still in its infancy, a recent qualitative study examining Nurse Practitioner/Family Physician collaboration in Ontario primary care practices has reported stories of role confusion, lack of awareness, and confusion of NP's scope of practice (Bailey et al., 2006). The consensus was that bringing nurse practitioners and family physicians together in a primary care environment without providing an adequate orientation does not cultivate collaborative practice. Researchers suggested that educational strategies related to role expectations should be introduced to aid partnerships and promote interdependent practice.

Given the importance of establishing effective collaboration and communication in health care teams, the current study will explore FHT member's perspective on collaborative practice, and will examine the different styles of collaboration/communication being utilized in these environments as well as evaluate their impact on work place satisfaction, nursing efficiency, wait times and positive patient outcomes. The study will also address whether nursing staff and other FHT member's feel they've been adequately prepared for working in these collaborative environments, particularly with regards to their training in effective communication styles. As a recent study being completed by the NHSRU uncovered a significant relationship between role ambiguity in nursing and negative patient outcomes in the acute care sector (O'Brien-Pallas et al, 2008), we will also explore whether nurses in FHT are experiencing similar challenges with regards to how their role is defined in these new practice environments.

This study is preliminary in nature, and will apply a mixed-methods approach to data collection and analysis, which will consist of both a qualitative analysis of participant's experiences working in FHTs, as well as a quantitative review of responses to surveys investigating collaboration and role conflict and ambiguity. Although this study is largely exploratory the researchers also hope to examine the data for trends linking collaborative practices to wait times, and job satisfaction and stress.

It is anticipated that the information collected will inform the Ministry of the FHTs' knowledge of effective communication styles, the extent to which topics of communication and collaboration are being/have been addressed in formal training, and provide insight into the impact of collaborative practices on both nurse satisfaction levels within FHTs, as well as population health outcomes, such as wait-times and patient outcomes.

## METHODS

### Research Questions

This study provides an examination of the work communication / collaboration practices within Family Health Teams. More specifically, the study was developed to explore the following research questions:

1. What challenges are nurses and nurse practitioners facing in the collaborative environments of Family Health Teams – what are the characteristics of the inter-professional communication styles being used, and what is most effective for contributing to Family Health Teams efficiency and a healthy workplace?

2. Are nurses and nurse practitioners receiving training in inter-professional communication/collaboration prior to forming Family Health Teams? Is there a need for continuing education in inter-professional communication for Family Health Team nurses and nurse practitioners?

3. What are the Family Health Team nurse demographics – Who are the nurses that are opting to form these new working environments (age, nursing experience, sector they are coming from, etc.)?

### Study Design & Methods

This was an exploratory study conducted to gain much-needed insight into the inter-professional collaboration and communication styles being utilized by healthcare professionals in Ontario's Family Health Teams. The research team examined the challenges that RNs, RPNs and NPs face in these collaborative environments, and evaluated the level of training in inter-professional collaboration being reported by Family Health Team members, with a particular focus on how these practices are impacting RNs, RPNs, and NPs' job satisfaction, stress, and capacity to treat patients.

Demographic data on the nurses working in this sector were collected, including information on the sectors these nurses worked in prior to forming their Family Health Teams. The researchers also investigated the means by which Family Health Teams are tracking patient wait times, and explored the feasibility of evaluating the association between wait times and collaborative practice.

**Study Recruitment**

A total of 8 FHTs from geographically diverse regions of Ontario were randomly selected to participate in the study. Each of these potential sites was contacted by telephone and formally invited to participate in this study. Following the call, a letter of invitation (see Appendix A) was sent to the Executive Director or nurse contact from each respective site via email and followed up by a phone call from a member of the research team.

The introductory letter requested the FHT's participation in the study via a one-time telephone interview with a nurse (RN, RPN, NP) from the FHT. In addition, an envelope containing a letter of introduction, consent form (see Appendix B), interview questions for the nurse participant (see Appendix C) and several short questionnaires (see Appendix D) for up to 10 applicable members of the FHT were sent to the contact at each of the 8 sites. Instructions were sent to the site coordinators regarding survey distribution to a cross section of the allied health professionals.

**Data Analysis**

The data analysis combined a mixture of qualitative and quantitative methods, relying primarily on a qualitative analysis of interview responses, with an additional quantitative analysis of survey responses. Quantitative analyses were conducted on the demographic data using SPSS v 16. Qualitative analyses were conducted on the interview notes using a content analysis approach.

## RESULTS

### Interview Participants

Interviews were conducted with eight nurse representatives from FHTs across Ontario. Job titles of the nurse participants interviewed included registered practical nurse (RPN), registered nurse (RN), nurse practitioner (NP), Nursing Coordinator, and Clinical Program Manager. Participating nurses averaged 39 years of age, and reported a range of 4 – 28 years of employment experience in nursing (*M*=15). Most had been employed in their current position for an average of 1.4 years, with five (62.5%) full time status and three (37.5) part time status. The nurse participants worked in FHTs across Ontario which varied in size from four to over 300 health professionals (median = 14).

Nurse participants varied in their level of educational preparation; all participants had completed either a BScN, or a Nursing Diploma; and 2 had completed a Primary Health Care Nurse Practitioner Certificate within the last three years. Nurse participants had previously worked in the acute care (75%), public health (12.5%), and primary care sectors (12.5%).

### Survey Respondents

A total of 74 surveys were sent out to participating sites; 10 surveys per site with the exception of one which only had four health professionals. A total of 56 surveys were returned to the NHSRU research offices, for an overall response rate of 75.7%. Of the survey's returned 23 were from nurses (41%), 10 were from physicians (18%), 9 were from other health care providers (e.g., social worker, dietician, psychologist, etc.) (16%), 4 were from pharmacists (7%), 3 were from administrative staff (5%), and the remaining 7 did not indicate any profession on the returned survey (13%).

## FINDINGS

### Motivation to join a FHT

Proximity to home, community of choice, and a steady work schedule emerged as the personal and lifestyle choices which influenced the nurses' decision to join a FHT. The unique model of care delivery facilitated by FHT's seemed to be another theme which emerged, with examples such as nurse-physician relationships in this setting, the opportunity to involve patient education as a part of treatment, teamwork, and a community health oriented approach to care given as examples of motivational factors influencing decisions to join a FHT. Despite these reasons three (37.5%) of the nurse participants noted that they did not make a conscious decision to join a FHT but instead were part of a practice which developed into a FHT, or applied for an available position which just happened to be within a FHT.

### Communication/Collaboration Training

Despite the anticipation that multidisciplinary health professionals should communicate and collaborate effectively to ensure coordinated and collaborative practice within a FHT, only 50% (4) of the nurse participants reported receiving communication or collaboration skills training prior to joining their team. For those who did receive training, it was primarily delivered through their formal educational programs (e.g., RPN diploma, RN baccalaureate, or NP certificate) and the feedback ranged from quite helpful to very effective. One exception was a nurse who received skills training provided by her employer in her previous position prior to joining the FHT.

The majority of nurses (62.5%) received training after joining their FHT. Interestingly the training was mostly provided by external organizations to a sub- group of the FHT rather than the whole and it consisted of conference presentations and workshops. One nurse reported receiving training provided directly by her FHT. The interviewee indicated that external facilitators were hired to coach skills and lead team building activities such as program planning as a group. Nurse participants reported a variety of feedback in regards to the training they received after joining the FHTs, with comments ranging from not that effective to very effective.

Communication/Collaboration skills' training was conducted in a variety of different formats. Training integrated into educational programs focused on the following facets of communication:

i. Leadership and communication.
ii. Roles and responsibilities (e.g., what is a good collaborator).
iii. Strategies for becoming more efficient when working as a team.

For the majority of nurses who received training after joining a FHT (3/5) it was provided by the Quality Improvement & Innovation Partnership (QIIP) Conferences. Nurses reported that this consisted of presentations followed by breakout sessions to discuss the importance of inter professional communication and address specific communication skills. A few other examples of programs or workshops which provided communication/collaboration skills' training to FHT members include a Regional Geriatric Program, which involved a 2 day workshop with group training. Health professionals were asked to complete a self survey and then groups were set up based on their communication styles (e.g., some people are enthusiasts some are idealists). Another example was a heart and stoke collaborative with the Ontario hypertension society; attendees talked about communication within their groups. One nurse received training provided by Health Canada, which consisted of inter-personal skills workshops and different collaborative approach retreats held over several weekends.

Only one (12.5%) out of the eight FHTs which participated in the study provided inter-professional communication and collaboration skills training to their staff which was designed to involve all FHT members. While the majority of interviewees (87.5%) received training either before or after joining a FHT, these typically did not include all the members of the FHT, and the training which was delivered was not consistent across the group. This was noted by some of the nurses as a significant limitation of the training. The sentiment was that in order for the training to be effective all members of the team should be present to learn the skills. One nurses also mentioned that collaboration and communication is an evolutionary process which requires maintenance to keep it working properly, and another expressed that she learned strategies but *"until you are actually in a situation where you have to put these strategies to work it's a completely different situation….. The importance of collaboration must be ingrained in everyone from the beginning (i.e, school). It must be recognized as an expectation of everyone. "*and these skills should be taught from the beginning of entering an educational program.

**Strategies to Enhance Inter-professional Practice**

Half of the nurses (50%) reported that their FHTs implemented in-house strategies to enhance interprofessional practice which included:

i. Team building retreat days.
ii. Monthly meetings of a clinical advisory group.
iii. Interprofessional education sessions.
iv. Allied health professional committees which met bi-monthly, this included a

professional from every different discipline within the FHT.

v. Monthly FHT clinical rounds, where a new topic was discussed (e.g., wound care).
vi. Case discussions, titled practice-based small group (PBSG) collaborations. Modules were provided by the faculty of medicine at U of T and the FHT had evidence-based case discussions facilitated by a physician.
vii. Increased frequency of staff meetings.
viii. Specific group (e.g., all the nurses, or all the physicians) and inter-professional group meetings (i.e., all the allied health professionals).

One FHT introduced a variety of strategies to target an identified gap created by physicians not attending the communication and collaboration training sessions, such as those provided by the QIIP. The sentiment was that it is inherently difficult to educate teams about collaboration and communication on an individual basis, therefore the FHT had an independent company organize team building retreat days. The nurse commented that this strategy was unsuccessful and indicated that it was a frustration felt throughout the FHT as the people they were really trying to engage (the physicians) were not interested in attend the sessions, if they could be working, or did not want to participate on their day off. A monthly meeting of their clinical advisory group was the second strategy to be established. These meetings reportedly had a number of the physicians in attendance and provided and opportunity to discuss any issues that warrant the full team's attention. Clinical advisory group meetings are apparently open to everyone and usually have representation from each of the allied health professional groups. This provides an opportunity to discuss the FHTs progress and any issues concerning QIIP (i.e., what programs they are running within the FHT for the community goal-setting and how the team is achieving those goals, how they work together as a group, etc.).

Inter-professional practice was addressed by one FHT by increasing the frequency of staff meetings, and engaging in regular group meetings (e.g., all the nurses or all the physicians) as well as regular inter-professional meetings. This is where the team discussed any issues related to flow of work, patient care or administrative matters. Reportedly the only downfall was that they *"only typically get one doctor there but that's what they expect"* which was a sentiment expressed by other nurse interviewees. The nurse commented that it was very difficult to encourage the physicians to take the time to communicate with the nurses which she mentioned can make it difficult for the nurses to know what they are supposed to do. She felt that half of the physicians really try to interact but one of the major barriers is workload, whereas the other half do not see the value in communication and collaboration and therefore *"don't buy into the fact that have to bother."* She did note that the Executive Director of the FHT was very committed to

communication, and encouraged FHT members to increase communication, especially between disciplines. Despite the encouragement from the Executive Director the nurse still felt that communication between professional groups was a struggle due to the tendency of groups to stick together.

One nurse commented that her FHT created several levels of in-service professional development training opportunities, and implemented interprofessional education sessions which the nurse noted were *"a good mechanism for getting people together"*. In this example, everyone on the team was invited to a presentation on a topic deemed relevant to everyone, and the presentation was given by one of the in-house experts or an invited guest speaker.

An allied health professional committee was set up by one FHT where a professional from every group (e.g., a nurse, a physician, management, social worker etc) was represented. The group met every couple of months, and provided the foundation for communication back and forth amongst the groups. Furthermore, they conducted FHT rounds every month where a new topic would be discussed (e.g., wound care, celiacs, how issues could be managed better across the board). The FHT rounds were augmented by practice based small group (PBSG) collaborations, a modular based skills training session provided through the faculty of medicine at the University of Toronto. The modules provided were evidence based and the FHT organized case discussions with the entire group which were facilitated by one of the physicians.

Half of the nurses who were interviewed (50%) indicted that their FHT had not implanted any additional strategies to enhance inter-professional practice. Moreover this group was not provided with any training in communication or collaboration skills by their FHT either before or after joining a FHT. All of these nurses received some training, however it was predominantly (3/4) provided as part of their nursing education and the one exception was a nurse who received training after joining the FHT, via conference presentations.

In summary, several strategies were adopted by FHT to promote effective inter-professional collaboration. These involved onsite and off-site team building retreats and workshops, the creation of forums for interdisciplinary dialogue and case review, and the creation of standing committees for allied health professionals.

**Inter-professional Relationships & Scope of practice**

All of the nurses described their relationships with the other health care professionals in their FHTs as good overall; with actual responses ranging from amicable to excellent. The majority (62.5%) reported that they were working to their full scope of practice, however there were those who commented that their scope was slightly limited due to the nature of their role in a FHT (25%). In one case a nurse mentioned that her FHT was in the process of discussing scope of practice and looking at changing how the nurses see the patients. Currently they only see their own patients, whereas the FHT was looking into patients booking appointments with nurses for procedures such as ear syringing and perhaps sutures. However it was noted that the decision around the extended scope of practice would ultimately be up to each nurse based on their individual comfort level. One nurse felt her scope of practice was very confusing due to a split between clinical and administrative responsibilities.

Most of the nurses (62.5%) felt that their FHT colleagues understood their roles and capabilities but noted that there was a definite learning curve. This was attributed to the fact that most of the physicians were not used to having a nurse working with them in a primary healthcare setting, and did not previously work closely with nurses prior to the inception of the FHT. Two of the nurses expressed that they are still in the process of educating others about their capabilities. One of the nurses interviewed felt that her scope of practice is a little confusing even for her, as well as everyone else on the team. This is due in part to the considerable administrative aspect of her position as she splits her time equally between administrative and clinical duties. According to this nurse there were not clear protocols in place for the course of action when one a clinical nurse is absent. Oftentimes she is required to assume clinical work to cover the nurse who is absent, while putting her administrative duties on hold and creating additional workload. Apparently this can also create confusion for the staff as they are unsure who to approach with administrative issues that she would usually handle.

One NP felt that during her nursing education she was taught that being a NP is *"all about autonomy, however while autonomy is great you need to be able to collaborate, that is what the role is all about."* She noted that this is what she uses to guide her practice and she expressed that a person's ability to collaborate has a lot to do with their background experience, which is why it is important to teach the importance of collaboration from the beginning (i.e., school), she also noted that the physician with whom she works has a lot of confidence in her which is good, however sometimes too much is expected and she misses the mentorship aspect of the collaborative partnership. She commented that it would be easier if they could informally discuss patient care with the physician to reassure her in the decision making process.

Another NP felt that she had to keep reminding other professionals of what she could and could not do at the beginning. Following on from this a nurse commented that it is *"particularly difficult for the physicians especially, to give up the control and understand the capacity of the nurse to do some of the work that they originally did, and give them the encouragement to move on".* They have provided physicians with lots of literature describing the scope of practice and capabilities of a nurse but it is not enough, the feeling is that there needs to be an ongoing face to face dialogue. She commented that a lot of physicians have already had 2 or 3 nurses that have been hired and then let go which she felt was a result of the physicians not having a sense of what the nursing role should be. Ideally, *s*he would like to see nurses doing well women visits, pap tests, independent diabetes care, and blood pressure management so the FHT is sending nurses for training to learn these skills, and then they provide education and update to the rest of the nurses. However she noted that in some cases the nurses are employed directly by the physicians and it can be a challenge to get physician approval for the nurses to attend the continuing education courses, especially when in her opinion "*there is a sense from a physician partner that they have ownership of the nurses."*

Relationships within the FHT were difficult at first, noted one nurse, as the administrative staff were employed directly by the physicians whereas the rest of the group was employed directly by the FHT. This created tension as the FHT employees did not feel that they were receiving relative compensation. However the FHT are now communicating much better which has consequently improved relationships. The whole team have recently compiled a collaborative proposal for an increase in their benefits which was submitted to their physician run board, as *"the same physicians who are part of the FHT also run the FHT as they are all on the advisory board"* which she mentioned was challenging and could perhaps been seen as a conflict of interest.

Denied access to monthly management meetings was mentioned by one nurse as a source of frustration as there is not currently a nurse representative present in these meetings. However, she did note that the nurses are approached by the Executive Director of the FHT to see if they have any issues which are then taken forward to the meetings on their behalf.

**Successes**

When asked to describe the successes that they have experienced to date in their FHT, the nurses provided the following examples:

i. Executive director made a huge difference in getting the FHT off the ground, really pulled everyone together.
ii. Increased scope of primary care nursing. The FHT allowed nurses to work outside their traditional role (e.g., anti-coagulation clinic where nurses performed point of care tests on patients and adjusted their dose based on their protocols).
iii. Opportunity to work directly with and learn from the other health professionals through treating different groups of patients (e.g., elderly and babies whereas in a hospital you would normally stick to one specific group of the population).
iv. Extra support and availability. Nurses are able to spend more time with the patients, "who are so grateful and receptive."
v. Enhanced patient care. In 4 months one nurse has been able to see 175 new patients.
vi. Implementing new programs such as: cancer screening, well baby clinic, a vaccination program, and a heart and stroke program.. One nurse reported picking up positive screens for colon cancer and monitoring pregnancies.
vii. Less emergency visits observed within the FHT since the introduction of the heart and stroke program. Program reportedly increased the time available for doing health promotion and screening rather than bridging the gap for people who have urgent problems.

**Challenges**

Alternatively, when asked to describe the challenges that they have faced as members of a FHT the nurses gave the following examples:

i. Encouraging staff to see the benefits of the FHT collaborative model of care, and encouraging physicians' participation in different programs and meetings.
ii. Employment relationships with physicians; sense from some physician partners that he or she has "ownership" of the nurses.
iii. Getting physicians to understand the nursing role and scope of practice, trying to establish criteria for when nurses can see patients as opposed to having a doctor's appointment.
iv. Billing issues. Physicians have to see all complex patients in order to charge an additional fee for service, undermines the FHT purpose.
v. Rostering. Even with NPs in the FHTs physician still see providing primary care as their responsibility, also rostering was seen as a control issue to start with.
vi. Finding an appropriate way to utilize NPs' experience and expertise.
vii. Resistance from the patients towards the NPs as they didn't feel they were seeing the right healthcare professional.

viii. History of difficult relationships with co-workers in the past.
ix. Expectation that the nurse should bring people together and be a peace maker and leader.
x. Misunderstanding or miscommunication with patients. Patients don't understand the referral process when the problem is outside the nurses' scope of practice which creates confusion about why they have to see someone else, therefore they don't fully understand the set up of a FHT.
xi. Knowing what the expectation is from the physician and FHT director with regards to the nursing role.
xii. Initiating programs such as hypertension , diabetes treatment and monitoring programs, due to the amount of time required to put them in place

**Effectiveness of the FHT Initiative**

The general consensus from the nurses was that the FHT initiative was extremely successful and working effectively, despite the challenges and barriers which the nurses pinpointed as areas for improvement. Aspects contributing to the effectiveness of the initiative include having all the professionals available under one roof which *"provides one-stop shopping"* and enables patients to self refer. Nurses felt that the initiative was really working to keep patients out of the Emergency room and provide the care that they require in a timely fashion which is inline with the MOHLTC top 2 healthcare priorities. Nurse to doctor ratio was increased in some cases from a challenging one nurse to eight doctors which was unmanageable. The FHT model of care provides a forum for nurses and physicians to communicate with other health professionals and determine the best method of treatment. In addition nurses commented that information can be imparted more freely to patients as they have more time available to spend with them as the FHTs move towards providing effective preventative care.

One nurse commented on the Heart and Stroke hypertension initiative and how easy it was to implement, she noted that this would be a good model to present to those developing additional programs and guidelines as it required minimal resources to get into place which is key when you are trying to provide effective care to a large population of patients.

*"People are becoming better about the rostering system, some people saw it as a control thing to start with and it isn't"* was one nurses' perspective. She felt that the members of the FHT were becoming more aware of how things work.

Another nurses commented that when she first joined the FHT she thought that patients would

come in and be triaged to determine if they would see the nurse or NP or go directly to the physician. She also commented that patients are still mostly coming in for the physician appointments and then going from there even though they have NPs who could be providing primary care. She noted that the physicians still see it as ultimately their responsibility and so are still limiting the number of patients they are taking on. They don't see the full benefit of the FHT model of care, and in some cases have stated that their workload has increased because of the extra allied health professionals and the consultations that they do.

One NP mentioned that her approach is to see patients and then inquire if they would like to see another health professional (e.g., dietician) as her *"fear is that care could become fragmented"* and she mentioned that she *"feels like the gatekeeper."*

**Enhance Effectiveness of Initiative**

When asked to provide suggestions to enhance the effectiveness of the FHT initiative, the nurses comments centered around the following themes: communication and collaboration, funding, education and structure/set up of the FHT.

*Communication and Collaboration*

Surprisingly only two nurses directly suggested that communication and collaboration is needed to enhance the initiative. The first noted that communication between the physicians and rest of the team is *"minimal at best",* due to confusion around the roles of each of the healthcare providers within the FHT. The nurse mentioned that it can be difficult to get a commitment of time from the physicians to attend inter-professional meetings and team building exercises, and having more than one physician at a time (i.e., the entire FHT together) is almost impossible. It was her belief that half of the physicians tried to commit time to communicate and collaborate but they have really busy case loads and the other half don't appreciate the fact that should collaborate. Additionally the nurse stated that some of the physicians are not physically on site very often which creates an obvious barrier to communication and collaboration. The other nurse stated that *"it must be recognized as an expectation of everyone"* to collaborate and doing this should be ingrained in all healthcare professionals from the beginning.

Two of the eight nurses recommended that additional staff are needed to champion and run programs within the FHT or at least provide support for the initial set up. If nurses could come in and establish programs such as the disease prevention programs, the end result would be a decrease in number of visits to the FHT, as well as a decrease in the number of visits to

emergency and hospitalizations, thereby resulting in an overall decrease in the need for patient care. It was felt by those interviewed that the FHTs need nurses and NPs to establish these programs, as well as communication with the physicians to encourage them to increase support and buy in for the programs. It was also suggested that higher NP numbers could increase the volume of patient care and decrease the number of consultations, as it is less efficient and more costly trying to increase the physician numbers.

One nurse commented that it would be beneficial if there was someone they could call to discuss any challenges they were facing, and who could provide strategies for improving inter-professional collaboration and communication. It was noted that someone with the knowledge and experience about how these things work, giving advice and guidance would be really helpful. It was also mentioned that this resource person's could save them time by perhaps implementing sessions such as "train the trainer", which would allow for a selected FHT member to pass on this individuals advice and expertise to the rest of the group.

*Funding*

Salaries and benefits were mentioned as a barrier to the effectiveness of the FHT initiative, as the salaries for nurses in FHTs are not in line with hospital salaries. One of the nurses interviewed commented that while there is not an expectation that FHTs would match hospital salaries, due to the obvious differences in the environment and the roles of the nurses. However, she did feel that the salaries are not competitive enough to attract and retain nurses in FHTs. Specifically she commented that in two years she has interviewed several nurses and only managed to hire a fraction of them; they get great nurses for interviews but *"as soon as they hear the salary and that there are no benefits they don't want the job….. the lack of benefits goes back to the fact that the nurses are employed by the physicians."* In addition, she intimated that there is no consistency within this sector as some nurses receive benefits through their FHT and some do not.

The billing structure was also mentioned as a barrier to effective collaborative practice, and an issue which should be addressed to facilitate the job of both nurses and NPs in the FHTs. Currently, physicians are required to see all the complex patients for billing purposes, even when these patients' care could be managed by another health professional. It was the opinion of certain interviewees that this is an inefficient use of time, and resources. The nurse commented that there needs to be criteria developed to address when a patient does not need to see a physician *"they should have an option to come to the RN or NP to help foster the whole health team plan"*. This was something that the nurses hoped could be addressed and resolved through a

conversation with the Ministry.

*Education*

Education was suggested as a strategy by two nurses. Specifically, educate health professionals about the importance of collaboration, and educating the community about the purpose of the FHT, as it was felt that they sometimes not sure how to utilize this model of care.

Improving the orientation for Nurse Practitioners was mentioned an additional strategy to enhance FHTs. Specifically, when an NP comes into a practice it was suggested that they allocate some time with each physician individually, similar in concept to a residency, where the NP can access the physicians on every patient to discuss their care. By establishing this access and communication, it was thought that both providers would have an opportunity to get comfortable with the expectations, limitations, and scope of each others practice. This recommendation compliments comments by two other nurses who felt that finding a fit for the Nurse Practitioner could sometimes be a problem, especially in those FHTs that had not previously had one. It was their opinion that the problem of finding the NPs role was due to a lack of understanding about their scope of practice from health professionals and patients.

*Structure/Set Up*

Revisiting the FHT structure and organization was suggested by two nurses as a way to improve the effectiveness of the FHT. One nurse suggested felt that a discussion with the entire FHT healthcare around the delegation of patients and patient care would be useful. Another nurse noted that there are challenges with regards to directing the activities and responsibilities of the nurses, as well as challenges involved in getting them out to professional development to learn new skills which would enhance their scope of practice, if they are employed by the physicians rather than the FHT. The opinion of this interviewee was that this was perhaps not the best employment structure, although it was noted that it can be a challenge within the larger FHTs.

Finally additional space in order to treat patients was noted as a strategy which would enhance the effectiveness of the FHT initiative.

**Wait Times**

Two of the nurses noted that they did not track wait times or they were not aware of their FHTs policy on wait times or whether they had a waiting list.

Three of the nurses noted that they were tracking the time that patients spend from the moment

they enter the FHT to the moment they leave after receiving medical care. Tracking was aimed at increasing the accessibility of care and one nurse mentioned that this was in a move towards an advance access model where patients can be seen on the same day that they call for an appointment. Two of these FHTs still have a waitlist for rostering patients, although one of them currently runs a NP led walk in clinic. The third FHT which is tracking patient time in the FHT has also implemented additional strategies to increase the accessibility of care for patients. These include acting as a liaison with a local shelter. Together they are building a system for people moving out of the shelter who don't have a physician, they can connect with the FHT head office to be matched with a physician who lives in their neighborhood or who speaks their language. The second is a telephone referral system for patients who do not have physicians as this is the objective of the family health team to absorb those patients. Patients phone the clinic and their information is sent to a physician who is taking on new patients.

One nurse noted that they did not have a wait list to see the physicians and patients are usually seen within 24-48 hrs. However they do have a waiting list for orphan patients from the community who don't have a family physician. This FHT have implemented a strategy where the nurse works through a binder of all the orphan patients. They receive at least two calls asking if they would like to come in and see the NP. This is not treated as a backdoor way to see the physician and the NP only refers the patient to the physician if there is a real need and the treatment is out with her scope of practice.

Two nurses commented that they did not have a waitlist for doctors in their FHT.

**Capacity to Treat**

Two nurses noted that they were not sure how their FHT was measuring its' capacity to treat patients. An additional three nurses noted that they did not have a formal method in place for measuring capacity to treat patients. However, one nurse noted that they keep track of how many patients they see in their urgent care clinics during the week and make note of instances when the numbers are increasing. Another nurse commented that they have noticed that their wait times are decreasing for programs (e.g, heart and stroke) to around 2-4 weeks depending on the program. This has freed up time for urgent rashes and sore throats etc, as they are starting to see a lot more preventative and health promotion visits. Finally the third nurse commented that they did not seem to be implementing anything outside of what they are doing for their QIIP program. QIIP's 3 objectives are: colorectal cancer screening, diabetes care and increasing access and decreasing wait times for patients. Through these 3 initiatives they have been trying to increase the capacity by which they treat patients.

Two nurses noted that the NPs at the FHT are filling out a statistical report every quarter on how many patients they see, the kind of treatment they give, referrals they provide and the screening they do, which is a Ministry initiative.

Finally one nurse stated that the wait time data has demonstrated that wait lists for the FHT are decreasing, as are the number of external referrals. It was mentioned that this FHT has also implemented an analysis of diabetes patients and an identification of when they were last seen. The goal is that the nurse or NP then brings in those patients every 3 months to get their care in hand and put them on a schedule. On the 2nd visit they may see the physician on the 3rd visit the dietician and on the 4th the pharmacist. This provides enhanced care for diabetic patients, and frees up time for the physician who can see more acute cases, thus clearing the wait list.

It is worth noting that an overwhelming majority (87.5%) of the nurses felt that the FHT is able to see more patients, or operate more efficiently than traditional Family Practices or Medical Clinics. One nurse commented *"it would not have been possible for a single physician without a nurse to see patients and provide reasonable care in 10 minute time slots. Unless it involved handing out prescriptions and getting them out the door but this is not quality care."* Another nurse mentioned that there is so much that nurses can do in a FHT that they are saving on medical appointments. They no longer require three visits to accomplish one task or eliminate one problem which has enabled them to open up their waiting list. The one nurse who did not agree chose to reserve her judgment, due to her limited experience working in family practice or medical clinic settings.

Reasons which were given to explain the FHT's capacity to see more patients or operate more efficiently included:

- Allied health providers together under one roof.
- Having nurses on board because people are choosing to see them for a lot of things and it takes the time away from physicians which they appreciate
- Increased numbers of NPs.
- Implementation of an electronic health record which enables information to be available with no delay for consultation notes.
- Programs which they have implemented e.g., diabetes.
- Ability to stream people to the right area and health practitioner.
- The RN and RPNs ability to see patients and provide care.

**Survey Data**

Although there are limitations to the survey data because of its relatively low sample size, the following results were observed when researchers examined the findings from the survey data:

On a modified version of The Jefferson Scale of Attitudes Toward Physician Nurse collaboration (Hojat, Fields et al. 1999), the mean score of all the respondents was 50.56. suggesting a positive overall attitude towards physician-nurse collaboration by the Family Health Team members. The highest scores on this measure were obtained by the nurses (Mean = 52.78), whereas physicians obtained the lowest scores of the occupational groups examined (Mean = 46.10). Although this difference was not statistically significant, it is consistent with other studies which have observed differences between nurses' and physicians' attitudes towards collaboration, with nurses generally sharing a more positive view of collaboration than physicians (Hojat et al., 2001).

On a scale derived from Baggs Collaboration and Satisfaction with Care Decisions scale (Baggs 1994), the overall mean score of all the occupational groups was 27.79, out of a possible total of 42, suggesting a fairly neutral level of satisfaction with collaboration (neither satisfied, nor unsatisfied). When the individual groups were examined nurses demonstrated only marginal differences in satisfaction when compared with physicians (mean scores of 30.04 and 27.7, respectively).

Lastly, on a modified scale designed to examine role conflict and role ambiguity (Rizzo, House et al. 1970) respondents demonstrated relatively low levels of role ambiguity (Mean = 13.35 out of a possible 30), as well as comparably low levels of role conflict (Mean = 21.89 out of a possible 40). When compared across occupational groups, most scores were comparable, with the exception of the Pharmacists, who reported a somewhat higher degree of role ambiguity relative to other occupational groups (Mean = 16.75).

## DISCUSSION

The discussion will centre on the three research questions which guided the research study.

### Research Question 1

What challenges are nurses and nurse practitioners facing in the collaborative environments of Family Health Teams – what are the characteristics of the inter-professional communication styles being used, and what is most effective for contributing to Family Health Teams efficiency and a healthy workplace?

#### *Challenges in Collaborative Environments*

The majority of challenges facing nurses and nurse practitioners in the collaborative environments of FHTs seem to be linked in some way to communication (inter-disciplinary and with patients) or the structure of the FHT. This is consistent with other studies which report that although there is an increased interest and commitment toward interdisciplinary communication and collaboration barriers still remain (King 1990; Bailey, Jones et al. 2006; Curran, Sargeant et al. 2007; Wiggins 2008). Nurses reported frustration when trying to get physicians to accept and adapt to the FHT model of care. Specific examples include: difficulty encouraging physicians to refer patients to other appropriate health professionals; a lack of physician participation in group training, programs and full team meetings; enabling the nurses who work with them to participate in professional development and; communicating their expectation to the nurses whom they are working with. This constitutes a major barrier to the success of the FHT initiative, and has been raised as a concern in a recent study by Soklaridis, et al (2007) where multi disciplinary faculty from 6 Ontario Universities noted that decisions should be made by the entire group of FHT otherwise the FHTs will revert to the traditional model of primary care which is apparent in physicians' offices.

One nurse reported a difficulty in finding a fit for the NP in her FHT as they that has not previous had one. The barriers included a lack of knowledge about their scope of practice and how to integrate a NP into the FHT model. A descriptive study conducted in Ontario in 2006 reported that integrating NPs into clinical practice with physicians without providing an adequate orientation does not produce collaborative practice (Bailey et al, 2006), which strengthens the findings from this study where the NPs noted that collaborative practice could still be a struggle

as other health professionals become accustomed to the role and her scope of practice, and in some cases where physicians would not discuss patient care with them. Additionally a pilot study examining the care provided by NPs and family physicians in Ontario identified that NPs were underutilized (Way, Jones et al. 2001) which would be expected if the role and scope of practice of NP was not clearly understood. Furthermore our finding that in the experience of our of our NPs the physicians felt that taking on additional patients when they had an NP partner was additional workload for them, irrespective of the fact hat the expectation is for NPs to provide primary care. This undermines the role of the FHT and should be addressed to enhance the effectiveness and efficiency of the initiative.

From the perspective of the nurses patient communication issues also existed. These issues originated from a lack of understanding of the FHT model of care and the role of the health professionals within it. Also, a lack of knowledge about the NP scope of practice, as it was mentioned that there was some resistance from patients towards the NPs, as patients did not feel that they were seeing the appropriate health professional. Furthermore some patients were apparently confused and frustrated when the nurse had to refer them to another health professional when the problem was outside her scope of practice.

Billing issues and time restraints when implementing programs in the FHT were the other challenges noted from the FHT collaborative environment.

***Inter-professional Communication & Collaboration***

Significantly, despite the expectation of inter-disciplinary communication and collaboration within a Family Health Team Model none of the nurses interviewed were provided with inter-professional communication or collaboration skills training by the FHT before they started in their roles. Half (50%) of the nurses had obtained previous training through courses integrated into their nursing education programs, (37.5%) of these nurses received this training as part of their RN baccalaureate, RPN diploma or Primary Care NP certificate, with the exception of one nurse who received inter-personal skills workshops and different collaborative approach weekend retreats, through a previous employer (12.5%). This is surprising given the evidence that suggests that that communication and collaboration should to be taught to healthcare professionals in schools and workplaces (King 1990; McEwen 1994; Kramer and Schmalenberg 2003; Selle, Salamon et al. 2008; Ontario Ministry of Health and Long-Term Care 2009) as it is not enough to insist that health professionals should collaborate when a lack of collaboration is oftentimes due to a lack of the relevant skills (Coeling and Cukr 2000).

The majority of nurses (62.5%) received some form of inter-professional communication/ collaboration skills training after joining the FHT, however only 25% of the nurses had this training provided by their FHT. The majority of nurses who received training after joining the FHT attended presentations, and breakout sessions provided by the Quality Improvement and Innovation Partnership (QIIP). This was established by the MOHLTC, and has been funded since January 2007 to support FHTs in Ontario. A regional Geriatric program and the Heart and Stroke initiative were examples of other sources of training for inter-professional communication and collaboration skills.

Whether training was received before or after joining the FHT, it is clear that the majority (87.5) of training sessions did not typically involved the entire FHT. This led to certain nurses questioning the effectiveness of the training they had received. Four of the nurses commented that not having the entire group present during training was a downfall even though the overall majority felt that the training they received was effective or very effective.

Implementation of a broad range of activities was the strategy employed by half of the FHTs to enhance inter-professional communication and collaboration. Activities included: team building; formation of clinical advisory groups/committees; inter-professional educational sessions; FHT rounds; practice based small group (PBSG) evidence based collaborations; and increasing the frequency of staff meetings. The majority of nurses felt that these approaches were helpful, although one nurse commented that *"the people they were really trying to capture (the physicians) didn't come to these sessions which was frustrating"*. According to the interviewee they allegedly didn't want to attend when they could be working and were not interested in attending on their day off. Despite this comment all 4 of the nurses felt that the relationships between health care providers in their FHTs were good with comments such as:

"*Great system of referrals and follow up and everyone is open to others suggestions and follow up."*

*"We often meet informally in the hallway or have meetings to share ideas, sometimes to review cases and discuss approaches. Nice to have input from diff provider angles into patient care."*

*"I like the way that we collaborate and there are always informal discussions. Everyone is very professional and yet open and available to talk and confer at any time."*

*"Quite good but it wasn't initially…..starting to think as a group"*

Interestingly, it should be noted that the majority of nurses who worked in FHTs that have not implemented additional inter-professional communication/collaboration skills training felt that their relationships were also good, very good or excellent with comments such as:

"*Communication is very very good between the health professionals currently on board."*
*"Relationships are professional, and positive and evolving over time, as they get to know each others roles."*

It would appear therefore, that although the implementation of strategies can enhance inter-professional communication/collaboration, innate communication skills, respect for each other's disciplines, and an understanding of the scope of each collaborator's practice also play a large role in the success of communication/collaboration. This is extremely positive and could provide the basis for an intervention study to test the effectiveness of the strategies listed above.

Determining the effectiveness of the above strategies in FHTs which have reported a lack of communication/collaboration or poor inter-disciplinary relationships, could lead to better patient outcomes as it has been reported that client outcomes and satisfaction with the care received, improve with collaboration (Hanson and Spross, 2005).

Due to the broad range of activities and training that nurse participants received to enhance in communication and collaboration and foster interprofessional care it is difficult to determine the most effective in contributing to the FHT efficiency and a health workplace. The FHT members surveyed indicated a positive attitude overall towards nurse-physician collaboration, a neutral level of satisfaction with the current level of collaboration, and a low level of role conflict. However the nurse interviewees did indicate that they felt that training was effective, and that the FHT initiative could be enhanced by increased communication and collaboration especially if training involved the entire FHT group including physicians.

**Research Question 2**
Are nurses and nurse practitioners receiving training in inter-professional communication/collaboration prior to forming Family Health Teams? Is there a need for continuing education in inter-professional communication for Family Health Team nurses and nurse practitioners?

***Training Prior to Joining Family Health Teams***

As mentioned earlier, despite the expectation of inter-disciplinary communication and collaboration within a Family Health Team model, none of the nurses employed in FHTs were provided with inter-professional communication/collaboration skills training by the FHT before they started in their roles. Furthermore those who did receive communication/collaboration skills training prior to joining a FHT received it as part of their nursing education. One nurse commented that communication and collaboration "is an evolutionary process which requires maintenance to keep it working properly", which would suggest that there is a need for continuing education in inter-professional communication for Family Health Team nurses.

A recent qualitative study (Soklaridis, Oandasan et al. 2007) interviewed faculty members from 6 universities in Ontario across a variety of health disciplines. Most participants expressed the need to support these FHT members by providing faculty development courses to teach health professionals how to work together. They also noted that there was a lack of understanding of what inter-professional education was, which can lead to confusion about how healthcare disciplines can collaborate. This view was also expressed in a qualitative study which stated that if healthcare professionals are expected to work together collaboratively then their education should also take place in a team setting to prepare them for this outcome (Romanow 2002).

Surprisingly only two nurses directly suggested enhancing communication and collaboration skills to enhance the FHT initiative. The first nurse noting that communication between physicians and the rest of the staff is minimal at best and it can be difficult to get a commitment of time. The second stating that *"it must be recognized as an expectation of everyone"* to collaborate. An additional two nurses noted that the FHT members need to talk more openly about the delegation of patients and patient care, and commented there are challenges when it comes to directing the activities of nurses and providing them with an opportunity to attend professional development courses when they are employed by the physicians, who may not grant them the time off. These are both challenges which could be addressed with more open communication around inter-disciplinary care and scope of practice. Additionally better orientation for NPs was another strategy suggested by a nurse to enhance FHTs. This would ensure that all providers can get comfortable with the expectations, limitations, and scope of practice of this role.

Therefore, 62.5% of the nurses felt that enhancing communication in some way among the healthcare providers could enhance the overall effectiveness and efficiency of the initiative by

demonstrating the importance of communication and collaboration in an inter-disciplinary model of care such as a FHT, and/or providing them with the tools to communicate openly.

These results suggest that the FHT members could benefit from continuing education in inter-professional communication and around the scope of practice of different healthcare providers despite the fact that survey respondents indicated a low level of role ambiguity.

**Research Question 3**
What are the Family Health Team nurse demographics – Who are the nurses that are opting to form these new working environments (age, nursing experience, sector they are coming from, etc.)?

Nurses who participated in this study had the title registered practical nurse (RPN), registered nurse (RN), nurse practitioner (NP), Nursing Coordinator, and Clinical Program Manager. Participating nurses averaged 39 years of age, and reported a range of 4 – 28 years of employment experience in nursing. Most had been employed in their current position for an average of 1.4 years, with 5 (62.5%) full time status and 3 (37.5) part time status. The nurse participants worked in Family Health Teams across Ontario which varied in size from 4 to 345 health professionals (median = 14). Furthermore educational preparation of the nurse participants varied; all participants had completed either a BScN, or a Nursing Diploma; and 2 had completed a Primary Health Care Nurse Practitioner Certificate within the last 3 years. Family Health Team nurses had an acute care background predominantly (75%), with others noting public health (12.5%), and primary care (12.5%) as areas of previous work experience.

The results from this FHT study strengthen the findings by a recent qualitative study examining Nurse Practitioner/Family Physician collaboration in Ontario primary care practices which reported stories of role confusion, lack of awareness, and confusion of NP's scope of practice (Bailey et al., 2006). This was also apparent in the Ontario FHTs. Both NPs and nurses who worked in FHTs alongside NPs noted the sense of role confusion with and confusion about scope of practice of the NP group. One nurses commented that the FHT had a difficulty in "finding a fit" for the NP as they had not previously had anyone in this role. "Educational strategies related to role expectations are necessary to facilitate the development of care delivery partnerships characterized by interdependent practice" (Bailey et al., 2006), and would likely enhance the effectiveness of NP/Physician partnerships and collaborations within FHTs.

## CONCLUSIONS AND RECOMMENDATIONS

The majority of nurse interviewees felt that the FHT initiative is extremely effective and a great model for patient care enabling the treatment of more patients than the traditional model of primary care. Surprisingly despite the expectation of FHT members to communicate and collaborative effectively none of the members were provided with skills training by the FHT prior to joining. Although 50% of the nurses stated that their FHTs were implementing strategies to enhance interdisciplinary communication and collaboration, they also reported challenges associated with full participation among all members of the FHT, which was seen to be counter-productive.

The goal of this exploratory study was to inform the Ministry of Health and Long-Term Care about the nurses who work in FHT and more specifically their knowledge of effective communication styles, the extent to which topics of communication and collaboration are being/have been addressed in formal training, and to provide insight into the impact of collaborative practices on both nurse satisfaction levels within FHTs, as well as population health outcomes, such as wait-times and patient outcomes.

### Feedback and Suggestions for the MOHLTC

Nurse interviewees were asked to provide specific recommendations to improve the overall efficiency of the Family Health Team. The most common recommendations centered around the improvement of communication and collaboration, to enhance inter-disciplinary practice and ensure that all healthcare providers are working to their full scope of practice, and to communicate more effectively with patients. The full list of suggestions includes:

1. Improve collaboration and communications to enhance inter –disciplinary practice.
2. Teach strategies for communication and collaboration to increase communication within the team, a model would be good.
3. Ensure people work to their full professional capacity
4. Encourage physicians to provide referrals for care for complex patients so other professionals can deal with appropriate aspects of their care.
5. Implement clinical meetings with all providers to enable conversation about patient care.
6. Encourage physicians to advise patients that they don't always need to be seen by the physician
7. Hire more RNs, NPs, Pharmacists and Psychiatrists.

8. Speed up the hiring process to enable the positions to be filled for all health professionals that they have funding for.
9. Develop chronic disease self management programs to help patients better manage their own care.
10. Educate the community to what a FHT does and advertise the concept to increase awareness (e.g., community newsletter).
11. Review structure of FHTs. Physicians who are hiring staff are also on the board governing the FHT which creates conflict of interests and impact team dynamics.

The following recommendations were provided by the research team based on study findings

1. Support research that is focused on communication/collaboration skills training and test the effectiveness of the interventions to enhance inter-disciplinary communication and collaboration.
2. Examine in more depth the cultural, professional, educational, and interpersonal factors that impact on nurses' ability to engage in full scope of professional practice.
3. Encourage demonstration projects that evaluate new roles for nurses within FHTs.
4. Investigate Community Health Centers' (CHCs) in more depth and the strategies that they use to support inter-professional communication and collaboration.
5. Investigate possible linkages between the FHT Initiative and the Aging at Home Strategy being implemented by the LHINs.
6. Identify a contact person within the MOHLTC who the FHTs can contact for support with problem solving and to determine best practices.
7. Keep funding the FHT initiative.

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## APPENDIX A

## INFORMATION/CONSENT SHEET FOR FRONT-LINE NURSE INTERVIEWS

Dear Nurse Participant

On behalf of the Drs. Diane Doran & Linda O'Brien-Pallas from the Nursing Health Services Research Unit (NHSRU), University of Toronto site, I would like to invite you to take part in a nursing research study related to Family Health Teams, inter-professional communication and collaboration and job satisfaction. The study is being conducted at the request of the Ontario Ministry of Health and Long-Term Care to explore communication and collaboration practices of health care professionals working in Ontario Family Health Teams, with a particular focus on how these practices are impacting RNs, RPNs, and NPs' job satisfaction, stress, and capacity to treat patients.

Participation in the study will consist of a one time telephone interview (approximately 45 minutes) with a nurse representative from your FHT, and completion of a short survey by 10 members of the FHT. If possible could you please distribute the surveys within all of the professional groups which are represented (i.e., nurses, physicians, social workers, dieticians etc.)

Please find enclosed consent forms, interview questions and 10 short questionnaires that have been sent to you along with postage paid return envelopes. It would be greatly appreciated if you could review and distribute the surveys and postage paid return envelopes to 10 members of your family health team and advise them to return the completed surveys to the NHSRU University of Toronto site. We are also requesting that you provide the interview questions and a consent form to a nurse in your team who expresses an interest in participating in the telephone interview. A member of the NHSRU's research staff will contact you within a few days to follow up on this introductory package and hopefully schedule an interview time with a nurse representative.

Your assistance, input and unique perspective is of tremendous value to our research and ensuring that the Ministry of Health and Long Term Care is provided with the most accurate and up-to-date information possible when evaluating and planning the future of the Ontario Family Health Team initiative.

If you have any questions about the study, please contact Dan Laporte, Research Officer at

the Nursing Health Services Research Unit, University of Toronto site (416) 946-0193 or rd.laporte@utoronto.ca.

Thank you for your time and consideration.

Sincerely,

## APPENDIX B

## INFORMATION/CONSENT SHEET FOR FRONT-LINE NURSE INTERVIEWS

## An Evaluation of Communication Practices in Ontario Family Health Teams

## CONSENT FORM FOR INDIVIDUAL RN/RPN/NP INTERVIEW

Introduction

You are being invited to take part in a nursing research study related to nursing work environments, inter-professional communication and collaboration and job satisfaction. This study is being conducted by Drs. Diane Doran & Linda O'Brien-Pallas and their research team at the Nursing Health Services Research Unit, University of Toronto site. The study is being conducted at the request of the Ontario Ministry of Health and Long-Term Care to explore communication and collaboration practices of health care professionals working in Ontario family health teams, with a particular focus on how these practices are impacting RNs, RPNs, and NPs' job satisfaction, stress, and capacity to treat patients.

Before agreeing to participate in this study, it is important that you read and understand the following explanation of the proposed study procedures.

Purpose

You are being asked to participate in a study, which will explore whether you or your FHT has received training in inter-professional collaboration or communication, as well as whether you feel such training would be beneficial. The study will also investigate whether a relationship exists between collaborative practices and job satisfaction, wait times, and FHTs' capacity to treat patients.

Procedures

The study will involve participating in a one time telephone interview (approximately 45 minutes) that will take place at your convenience. If you agree to participate the researcher will also ask that you complete one of the short questionnaires that have accompanied this letter and return both this consent form and the questionnaire to the NHSRU's offices in the self-addressed stamped envelope that has been provided for you. Individual telephone interviews will be recorded, and taped discussions will then be transcribed.

Risks

The risks to participants in this study are minimal. Some participants may experience some emotional distress when speaking about workplace concerns they may have.

Benefits

Study participants may not directly benefit from participation, however, your contributions to the understanding of positive nursing work environments and nurse job satisfaction may be used to for designing more effective Family Health Teams in the future.

Confidentiality

All information obtained during the study will be held in strict confidence. Only members of the research team will have access to the study data. No names (or other identifying information) of individual participants or employers will be used in any publication or presentation of the study results. The information shared in your interview will not be shared with anyone else in your organization.

Voluntary Participation

Your participation in this study is voluntary. You can choose not to participate or you may choose to withdraw at any time without it affecting you in any way.

Questions

If you have any questions about the study, please contact Dan Laporte, Research Officer at the Nursing Health Services Research Unit, University of Toronto site (416) 946-0193 or rd.laporte@utoronto.ca.

Consent

I have had the opportunity to review the study purpose and my questions have been answered to my satisfaction. I consent to take part in this study with the understanding that I may withdraw at any time without affecting my employment status. I have signed a copy of this consent form and I voluntarily provide my consent to participate in this study.

_____ _____

Name and job title (Please print) Date

_____

Participant Signature

## APPENDIX C

## QUESTIONS FOR INDIVIDUAL RN/RPN/NP INTERVIEW

Demographic data to be captured

- Age:
- Gender:
- Job title:
- Years of work experience in nursing:
- Education:
- Years in current job:
- Part-time or full-time status:
- Sector you worked in prior to forming a Family Health Teams:
- Structure of your Family Health Team (i.e., how is the FHT staffed):
- In addition, NPs will be asked to provide information about
    - where they completed their NP training
    - date completed and
    - previous employment in an NP role:

1. What motivated you to join a FHT?

2. Did you receive any formal / informal inter-professional communication / collaboration training before or after joining a FHT? If yes, how effective has this training been?

3. If training as been received, what form did it take (e.g., part of nursing curriculum, individual courses, group training for FHT Members)?

4. Has your FHT engaged in any additional strategies to enhance inter-professional practice?

5. How would you describe the relationship that you have with the other health care professionals in your FHT?

6. Has your FHT engaged in any strategies to enhance inter-professional practice?

7. How would you define your scope of practice within the FHT? Do you feel the other members understand your role within the FHT, and your capabilities as a health care practitioner?

8. What are some of the successes and challenges that you have encountered during your time in the FHT?

9. How would you describe the effectiveness of the FHT initiative?

10. What, if anything, would you suggest could be done to enhance the initiative?

11. Are you aware of whether your FHT is tracking patient wait times? If so, can you describe how they are tracking them? Do you have a wait-list for patients? If so, how long are patients on your wait lists?

12. How are you measuring your unit's capacity to treat patients?

13. Do you feel your FHT is able to see more patients, or operate more efficiently than traditional Family Practices or Medical Clinics? If so, what do you feel accounts for this?

14. What recommendations do you have for improving the efficiency of your Family Health Team?

## APPENDIX D

## QUESTIONNAIRES TO BE COMPLETED BY MEMBERS OF THE FHT

- The 3 short surveys listed below are to be completed by members of the Family Health Team.
- Once completed please return this questionnaire in your enclosed postage paid envelope.
- **Please indicate your position within the FHT (i.e., nurse, physician, social worker, dietician etc):_____**

### Survey 1

For each question, please select one of the following:

*1 = strongly agree, 2 = agree, 3= disagree, 4 = strongly disagree*

---

| | | | |
|---|---|---|---|
| 1. | During their education, medical and nursing students should be involved in teamwork in order to understand their respective roles. | 1<br>3 | 2<br>4 |
| 2. | Inter-professional relationships between physicians and nurses should be included in their educational programs. | 1<br>3 | 2<br>4 |
| 3. | A nurse should be viewed as a collaborator and colleague with a physician, rather than his or her assistant | 1<br>3 | 2<br>4 |
| 4. | There are many overlapping areas of responsibility between nurses and physicians | 1<br>3 | 2<br>4 |
| 5. | Physicians should be educated to establish collaborative relationships with nurses. | 1<br>3 | 2<br>4 |
| 6. | Physicians and nurses should contribute to decisions regarding the hospital discharge of patients. | 1<br>3 | 2<br>4 |
| 7. | Nurses should also have responsibility for monitoring the effects of medical treatment. | 1<br>3 | 2<br>4 |
| 8. | Nurses are qualified to assess and respond to psychological aspects of patients' needs | 1<br>3 | 2<br>4 |

| | | | |
|---|---|---|---|
| 9. | Nurses should be involved in making policy decisions affecting their working conditions | 1 2 3 4 | |
| 10. | Nurses have special expertise in patient education and psychological counseling. | 1 2 3 4 | |
| 11. | Nurses should clarify a physician's order when they feel that it might have the potential for detrimental effects on the patient. | 1 2 3 4 | |
| 12. | Nurses should be involved in making policy decisions concerning the hospital support services on which their work depends. | 1 2 3 4 | |
| 13. | Nurses should be accountable to patients for the nursing care they provide | 1 2 3 4 | |
| 14. | The primary function of the nurse is to carry out the physician's orders. | 1 2 3 4 | |
| 15. | Doctors and nurses should have equal authority in all health care matters. | 1 2 3 4 | |

## Survey 2

For each question, please think of the last patient you treated on the most recent day you worked, and select one of the following:

*1 = strongly agree, 2 = agree, 3 = somewhat agree, 4=, neither agree nor disagree 5 = somewhat disagree, 6 = disagree, 7= strongly disagree*

---

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. | Nurses and physicians planned together to make the decision about care for this patient. | 1 | 2 | 3 | 4 | 5 | 6 7 |
| 2. | Open communication between physicians and nurses took place as the decision was made for this patient | 1 | 2 | 3 | 4 | 5 | 6 7 |
| 3. | Decision making responsibilities for this patient were shared between nurses and physicians | 1 | 2 | 3 | 4 | 5 | 6 7 |
| 4. | Physicians and nurses co-operated in making this decision | 1 | 2 | 3 | 4 | 5 | 6 7 |
| 5. | As this decision was considered, nurses and physicians each actively represented their professional perspectives about this patients needs | 1 | 2 | 3 | 4 | 5 | 6 7 |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 6. | Decision making for this patient was coordinated between physicians and nurses | 1 | 2 | 3 | 4 | 5 | 6 7 |

## Survey 3

For each question, please select one of the following:

*1 = strongly agree, 2 = agree, 3 =, neither agree nor disagree 4 = disagree, 5 = strongly disagree*

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. | I feel uncertain about how much authority I have. | 1 | 2 | 3 | 4 | 5 |
| 2. | Clear, planned goals and objectives do *not* exist for my job | 1 | 2 | 3 | 4 | 5 |
| 3. | I know that I have divided my time properly. | 1 | 2 | 3 | 4 | 5 |
| 4. | I'm not sure what my responsibilities are | 1 | 2 | 3 | 4 | 5 |
| 5. | I know exactly what is expected of me. | 1 | 2 | 3 | 4 | 5 |
| 6. | Explanation is clear of what has to be done on the job | 1 | 2 | 3 | 4 | 5 |
| 7. | I have to work on things that should be done differently. | 1 | 2 | 3 | 4 | 5 |
| 8. | I work on unnecessary things. | 1 | 2 | 3 | 4 | 5 |
| 9. | I seldom receive an assignment without the manpower to complete it. | 1 | 2 | 3 | 4 | 5 |
| 10. | I work with several groups that operate quite similarly. | 1 | 2 | 3 | 4 | 5 |
| 11. | I receive assignments without adequate resources and materials to complete them. | 1 | 2 | 3 | 4 | 5 |
| 12. | I usually do not have to "buck a rule" or policy in order to carry out an assignment. | 1 | 2 | 3 | 4 | 5 |
| 13. | I seldom receive incompatible requests from two or more people. | 1 | 2 | 3 | 4 | 5 |

| | | | | | |
|---|---|---|---|---|---|
| 14. | I do things that are likely to be accepted by one person, but not accepted by others. | 1 | 2 | 3 | 4 | 5 |

**Thank you for taking the time to complete this questionnaire.**

Please return your completed questionnaire using the pre-paid return

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