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# Transformation of primary care settings implementing a co-located team-based care model

*A scoping review*

Obj.

## Objectives

- **Understand the operationalisation of interprofessional care models (organisation and coordination of services)**
- **Describe the needs and contexts for the emergence of interprofessional care models**
- **Identify the impact of these models on patients, professionals and their economic impact**

In Canada, primary care reforms have led to the implementation of interprofessional models to improve access, integration and prevention in patient care, but challenges remain [1]. Despite the creation of Family Medicine Groups (FMGs) in Quebec, a considerable proportion of the population still has no access to a family doctor or psychosocial services, and hospital emergency departments are overcrowded [2]. It is therefore important to gain a better understanding of how interprofessional models work on the front line in order to determine what is effective, with a view to identifying the elements that will contribute to better meeting the needs of populations in Quebec and elsewhere.

## Methods

Inclusion criteria for the Scoping Review

- Interprofessional models in primary care (outside the hospital setting)
- Presence of a physician in the team
- Team assembled in a point of service ('co-location')
- Services provided by professionals are part of the general range of services (excluding programmes dedicated to a specific pathology)
- Available and sufficient information about the models' functioning in the field and the effects of these models on the population, professionals or health system costs

5952 studies verified

**15 studies analysed**

*[1] Aggarwal M, Hutchison B. Toward a primary care strategy for Canada. Ottawa (CA): Canadian Foundation for Healthcare Improvement; 2012.*
*[2] Plourde A. Bilan des groupes de médecine de famille après 20 ans d'existence : Un modèle à revoir en profondeur. Montréal: Inst Rech Inf Socioéconomiques; 2022. p. 1–25. Corps.*

# Principal Results

## 1 Composition of teams, optimisation of roles and organisation of services

- There is considerable variability in the way the models are put into practice, particularly in terms of the types of professionals present, which influences the types of services offered.
- The models identified did not include any rehabilitation disciplines (e.g., occupational therapy, kinesiology, physiotherapy), and none addressed the role of administrative staff.
- The physician is most often the point of entry for assessing patients' needs and referring them to the right professional; some models rely more on nurses (registered nurses, advanced nurse practitioners).
- The support of managers is a key success factor for the implementation of these models.
- Collaborative tools, in particular shared electronic medical records (EMRs) and interprofessional meetings, as well as the presence of professionals on the same site, are crucial factors for success.
- The patient has not been identified as a full partner in interprofessional collaboration in these models.

## 2 Design of models according to the specific characteristics and needs of a sector

- These models are generally established to respond to specific types of clienteles, either people living with mental health problems or chronic illnesses, but rarely both. Some models focus on vulnerable or marginalised populations.
- No single set of criteria for implementing these inter-professional models has emerged. Careful study of the specific characteristics and needs of a sector is essential to developing a model that will meet the needs of the population.
- Several factors need to be considered when establishing the models: the type of area (urban, suburban, rural), the population's needs in terms of services (e.g., mental health, chronic diseases), and the type and ratio of professionals available in the area. A clear understanding of the needs of the population and the characteristics of the sector will help to determine the services to be offered and the type of professional to be included accordingly, considering the sector's possibilities.

## 3 Limited integration of health outcomes, patient and provider experience and healthcare costs

- Overall, the models appear to meet the expectations of an effective interprofessional primary care model for both patients and professionals. However, although although prevent and patient self-management are primary care reform objectives, the articles did not address these elements.
- There are few results concerning the cost-effectiveness of the models, in contrast to the qualitative results analysing the subjective experience of patients and/or professionals. This shows a lack of integration of economic and qualitative aspects in the evaluation of models.
- The facilitating factors highlighted include the way professionals are funded and remunerated, the presence of a case manager or service coordinator, the physician's adherence to the model, staff stability, individual skills and a shared vision of the model and services.

# Key takeaway messages

The variability of the results reveals the **complexity** of implementing the models; it is impossible to identify a single ideal model or universal characteristics for their implementation. It is essential to assess the characteristics and needs of a population in each area to design a model that meets those needs. The selection of the professionals to be included in the service offer is important if the needs of the population are to be adequately met.

A **collaborative approach** - involving a range of stakeholders, including healthcare professionals and patients - seems essential. Co-construction between these stakeholders is relevant at every stage of the process: from needs assessment to the implementation of the model in the community, via the design of the care and service model. Continued support and involvement once the model has been implemented are essential if it is to function effectively in the field.

An **integrated approach**, considering systemic (funding, favourable policies and government), organisational (co-location, effective leadership, collaboration tools), inter-individual (communication, common goals) and individual (commitment and interest in collaboration) aspects, is also essential. The **funding** of the model and the way professionals are remunerated are key factors, among others, in the successful implementation of models.

Finally, reflection is required about the best indicators for **assessing the efficiency** of a care model, as well as the methods for collecting data on these indicators.

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