THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

BEST ADVICE

Communities of Practice in the Patient's Medical Home

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INTRODUCTION

As clinical leaders, family physicians have the power and responsibility to meet the needs of the communities they serve. Family physicians have a crucial role as generalists providing continuing comprehensive care. It is important to acknowledge that the delivery of family medicine services is evolving, and to continue to provide this care family medicine offers a wide variety of practice types in which physicians may choose to develop special interests. In the Patient's Medical Home (PMH) model, team-based practices promote continuity and comprehensiveness of care to best serve patients and accompany them on their life journeys. These team-based practices are likely to include intraprofessional collaboration between family physicians.

An important distinction to make, which is dealt with more fully later in this guide, is that these communities of practice in family medicine (CPFMs) are not required to be geographically contiguous. CPFMs may exist across distances with physicians working together remotely or through technology for issues of common interest and need.

What are communities of practice?

Communities of practice have been defined as "groups of people who share a concern, a set of problems, or a passion about a topic, and who deepen their knowledge and expertise in this area by interacting on an ongoing basis."[1]

Communities of practice in family medicine (CPFMs) can include clubs, committees, associations, academies, study groups, coalitions, email discussion lists, interprofessional care teams, and community-based primary care groups.[2]

Therefore, in this guide, the concept of CFPMs refers to intraprofessional collaborations in care delivery between family physicians. Physicians that constitute CPFMs can be broken down into two categories:

- **Family physicians with special interests** (FPSIs) provide comprehensive continuing care to their patients, and include one or more areas of special interest as integrated parts of the broad scope of services they provide
- **Family physicians with focused practices** are FPSIs who are committed to one or more specific clinical areas as major part-time or full-time components of their practices

Providing patients and communities with services that meet their needs should remain a priority for family physicians. This means that a physician who chooses to develop an area of special interest should continue to serve as a most responsible provider to a population of patients and offer call services.
On the other hand, the in-depth knowledge of physicians with focused practices should not be viewed as a way to take that particular domain out of the scope of practice of comprehensive physicians. Areas such as intrapartum and palliative care continue to be integral parts of full-scope family medicine. Focused-practice colleagues can empower full-scope family physicians in providing these services and offer support in cases where additional expertise is required.

Intraprofessional or interprofessional?

The flip side of the ***intra*professional** communities of practice teams is the broader ***inter*professional** team structure in a PMH that incorporates other health professionals, such as nurses, dieticians, and social workers. This makes for a close but important distinction. This Best Advice guide is the first of two covering the topic of teams; the second guide addresses interprofessional team-based care in the PMH model.

The College of Family Physicians of Canada (CFPC) offers programs that cover a range of areas that members have expressed an interest in—be they part of comprehensive care practices or, in some cases, major or full-time commitments. CPFMs have been established in clinical domains such as addiction medicine, cancer care, chronic pain, emergency medicine, mental health, and sport and exercise medicine. Go to Section of Communities of Practice in Family Medicine for a comprehensive list of CPFM programs.

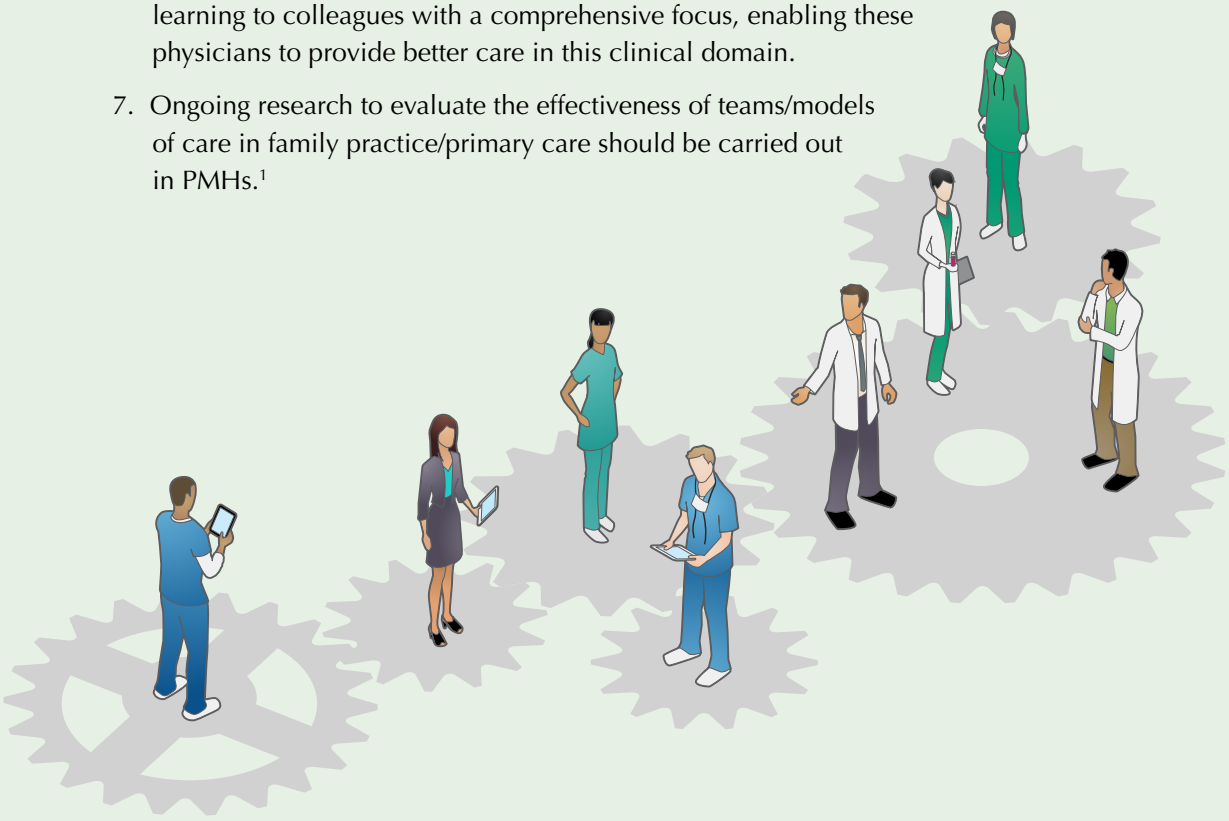
This guide focuses on collaboration between family physicians. This focus should not detract from the crucial role that physicians of other specialties play as part of the PMH. Collaborating with colleagues working in other disciplines is imperative in helping family physicians connect their patients to needed services. While reviewing the advice in this document, family physicians—both those in focused practices and those providing comprehensive care—should be keenly aware of scopes of knowledge and skill of all health professionals involved in the care of their patients.

There are not always ready structures in place to support the approaches listed in this document. However, we hope that the successful case studies listed here provide examples of possible achievements. These achievements should serve as powerful motivation for developing the infrastructure to allow for this kind of collaboration. The PMH model offers a robust base that encompasses both comprehensive care and possibilities for enhanced expertise in areas of focus.

Guiding principles

Within the PMH, the following guiding principles promote comprehensiveness of care, responsiveness to community needs, and the role of collaborative delivery models:

1. Family physicians with special interests or skills, along with other medical specialists, should be part of a PMH, collaborating with the patient's personal family physician to provide a comprehensive, broad range of primary care and consulting services.[1]
2. Practices should offer patients a broad scope of services carried out by teams or networks of providers, including each patient's personal family physician working with peer family physicians and other specialist physicians, nurses, and other health care professionals.[3]
3. Shared-care models that support timely medical consultations and continuity of care should be encouraged and supported as part of each PMH.[1]
4. The composition of the teams or networks of health professionals and providers in PMHs may vary, based on community need.[1]
5. Family physicians with special interests or skills are encouraged to participate in research and to teach medical students, residents, and other learners, enriching the overall family medicine learning experience.
6. Family physicians with special interests or skills can also provide formal and informal learning to colleagues with a comprehensive focus, enabling these physicians to provide better care in this clinical domain.
7. Ongoing research to evaluate the effectiveness of teams/models of care in family practice/primary care should be carried out in PMHs.[1]



OBJECTIVE

The objective of this guide is to provide actionable advice for establishing and maintaining communities of practice for:

- Full-scope family physicians who are interested in fostering intraprofessional collaborations to enhance the scope of their comprehensive practice
- FPSIs and family physicians with focused practices who want to join a comprehensive care setting while maintaining those interests

While this guide is presented for the consideration of those in all types of family practice, the strategies described involve many important components of the PMH model. The model emphasizes providing patient-centred care that is compassionate, equitable, continuous, and comprehensive.

THE ROLE OF FAMILY PHYSICIANS WITH SPECIAL INTERESTS AND FOCUSED PRACTICES

Family physicians with special interests (FPSIs) and family physicians with focused practices can supplement their core skills and experience with additional expertise in a particular field, while remaining committed to their core generalist role.[4] The work of FPSIs and family physicians with focused practices is about developing the health workforce and delivering appropriate care when and where it is necessary. These family physicians work within the scope of their training, competence, and expertise to deliver the most appropriate services and to meet patient needs. They can always draw extensively on their generalist training and approach to disease management, and patient-centred care, enabling them to work collaboratively at different levels of care, including with other specialists, to meet patient needs.[5] These clinicians also serve as a resource for other physicians in their local health system by enhancing care delivery and learning and teaching opportunities.

Family physicians who gain these additional competencies through advanced clinical training or years of clinical experience, can provide services that are otherwise not available in a given area, particularly in remote and rural communities. Overall, physicians practising in a rural region are more likely to report having a focused practice. According to the 2013 National Physician Survey, approximately 71% of family physicians in rural areas have a focused practice in emergency medicine as opposed to 40% of their counterparts in urban areas. Similar trends can be observed in different areas of focus, including hospital medicine (59% versus 47%) and family medicine anesthesia (10% versus 5%). Practising in rural areas, these physicians often complement their comprehensive skill set with areas of added expertise to best meet the needs of the populations they serve. Where appropriate, family practices can have a care team with enhanced professional competencies and appropriate skills to meet local needs.[6]

Case-study: Family physicians in emergency departments

A community-based family health team (FHT) in Brampton, Ontario, has 17 family physicians. All physicians provide a full scope of in-office family medicine care to their unique rosters of patients. Three of the physicians also work in the emergency room (ER) on a regular basis and have certificates of added competence (CACs) in emergency medicine. Emergency medicine (EM) is an area where the CFPC offers formal recognition of enhanced skills training to family physicians. A significant part of emergency care in this country is provided by family physicians, with or without an EM designation.

Communication among the physician partners in the Brampton FHT is regular, informal, and supportive. The physicians who work in the ER regularly provide support to those who do not. When patients arrive at the medical office with suspected simple fractures, the ER physicians review X-rays with the physicians who do not practise in the ER. They assist with splinting in the office, helping the patient avoid an ER visit. Their support and guidance facilitate greater competence among the other physicians, and new partners who join the practice quickly learn to provide care for simple fractures that no longer require ER visits, only follow-up in the outpatient fracture clinic.

COMMUNITIES OF PRACTICE IN ACTION

Family physicians can foster intraprofessional collaborations and establish communities of practice in different ways. Some may choose to include physicians with special interests as a part of their multidisciplinary team, while others develop formal consultative arrangements with focused practices in their communities.

FPSIs can also work in a variety of settings. For example, emergency medicine is one field where family physicians are essential to the delivery of care. They can use their unique abilities to guide patients through an increasingly complex health care environment, ensuring continuity of care.[6]

Mental health is another example to consider. Integrating mental health services within primary care settings has improved access to mental health care and increased the capacity of primary care to manage mental health and addiction problems.[7] Successful projects in Canada and other countries demonstrate that collaborative models delivering mental health services lead to better clinical outcomes, a more efficient use of resources, and enhanced experiences of seeking and receiving care. Access to services and quality of care and support for people with mental health and addiction issues can be improved through better collaboration between providers and services, promoting continuity and comprehensiveness of care.[7] Collaborative care is care that is delivered by providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual support.[7] Family physicians with special interests in mental health or addiction medicine have a significant role to play in the integration of these services.

WHY COMMUNITIES OF PRACTICE?

Developing communities of practice in family medicine can lead to a streamlined delivery of health care services that meets community needs in a timely and equitable way. Research about the impact of primary care in general and experience from current practices reveals many anticipated benefits. Many of these are in direct alignment with the PMH model and can augment the same results that the PMH strives to achieve.

Enhancing knowledge and clinical skills in the PMH

The presence of family physicians with enhanced skills will broaden the knowledge and clinical abilities of the practice team overall. Family physicians benefit from communities of practice by learning from and working with others to accelerate practice improvements, which leads to an improved overall group competency.[8] By working together, family physicians have the opportunity to share clinical cases, listen, reflect, and receive feedback about processes of care for complex patients. These collaborative work environments allow physicians to share best practices, nurture relationships, develop solutions, and generate new ideas and innovations.[9]

Comprehensiveness in the PMH

Communities of practice ensure a diversity of knowledge and skill sets, broadening the range of services a practice offers. By offering a comprehensive range of services tailored to community needs, family practices provide patient-centred care that responds to patient preferences, needs, and values.[10] Patients can receive comprehensive services that are needed within their own communities, improving access and allowing patients to be treated in a family practice setting closer to home and potentially avoid hospital visits.

Continuity of Care in the PMH

By providing an expanded level of health care services in the PMH, patients can receive care in a familiar environment from care providers with whom they have established a relationship, including a family physician as a most-responsible provider. Patients benefit from continuity of care from well-connected teams with the same overarching philosophy of care. Practices collaborating with FPSIs and family physicians with focused practices have direct lines of communication, allowing them to discuss care plans and leading to an enhanced continuity of care across providers.

Timely access to services in the PMH

Keeping care closer to home by delivering additional services in family practice settings or forming networks with focused practices in the community can provide improved access to care in specific areas. This includes:

- Reduced wait times[3]
- Access to services that would otherwise be difficult to reach, particularly in rural and remote communities[3]
- Decreased travel time for patients, thereby reducing time away from families, employment, and so on[3]

Refer to the Best Advice guide *Timely Access to Appointments in Family Practice* for more information about effective strategies to promote timely access in a primary care setting.

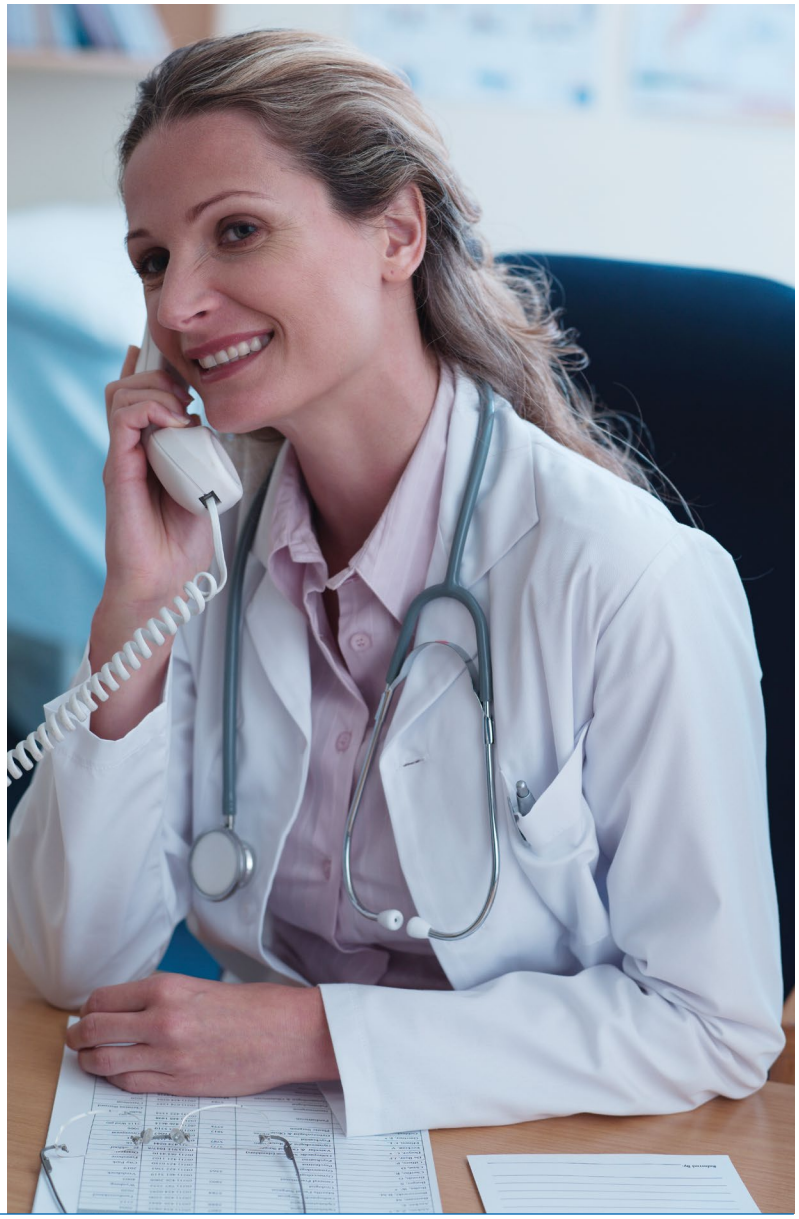
Efficient use of resources

Research demonstrates that health services delivered in primary care settings are generally more cost efficient.[11] Collaboration is a key tenet of primary care and is consistent with the PMH model.[7] Well-organized collaborative partnerships in primary care can result in cost savings without a reduction in service.

Streamlined patient pathways

By providing the appropriate mix of team members, including FPSIs, family physicians can streamline patient pathways through: [3,7]

- Removing unnecessary steps (eliminating redundant follow-ups, placement on waiting lists, etc.)
- Preventing the need for more costly interventions
- Avoiding duplication of services
- Facilitating the flow of patients from one service to another and removing barriers to access by providing appropriate referral to secondary or tertiary hospitals when needed[§,12]



[§]Research about the role of family physicians in South Africa has shown that they are critical for managing patients and reducing referrals to secondary or tertiary hospitals.

STRATEGIES TO INCORPORATE COMMUNITIES OF PRACTICE IN THE PMH

This section provides strategies for organizing communities of practice in a clinical setting. Strategies will focus on how to engage with FPSIs and how to connect with focused practices.

Identify community needs

Family physicians are encouraged to identify the gaps in health care provision in their local practice environment and determine whether family physicians with added skills may be able to meet those needs. Data from electronic medical records—as well as input from patients, community members, and stakeholders—can provide information about the health challenges faced by patients in the community. Based on community needs, practices can choose to include an FPSI as part of their multidisciplinary team, or form formal consultative arrangements with a family physician with focused practice.

It is important to keep in mind that the nature of a geographically-defined community may change over time and the skill sets of the collective practitioners must similarly evolve. This needs assessment should be conducted on a continual and iterative basis so that any changes in community health care needs are recognized and acted upon. This could mean current family physicians enhancing their skills in relevant areas, adding physicians with enhanced skills to the health care team, or connecting with local focused practices to promote comprehensiveness of care. This is a developing area with new best practices being learned by those who attempt this integration; by sharing their own experiences, physicians can help similar work in other communities.

Case study: Identification of community needs

A general practitioner in oncology (GPO) working in Fredericton, New Brunswick, resides in the outlying rural community of Harvey. Over time, a process has developed where the GPO stops at the local health centre in the rural community when travelling home from the tertiary care centre. The GPO meets patients, thereby minimizing travel time and costs for them. The process is efficient and appreciated.

Occasionally, the local family physician and GPO cross paths in the local centre and discuss any complex new oncology referrals. In order to continue to minimize travel for rural patients and work collaboratively with local family physicians, the GPOs in Fredericton also offer telehealth visits for satellite clinics in the Woodstock and Perth areas. The patient's family physician performs a physical exam and sends a note to the GPO prior to the scheduled telehealth visit. The GPO reviews the note and meets with the patient via telecommunication. The patient is accompanied by an oncology nurse who can help clarify any information. These telehealth appointments are very convenient for appropriate patients.

To coordinate cancer care between providers, the GPOs perform the following: field phone calls and emails from family physicians regarding specific management questions; provide updates on relevant new developments in medical oncology through the hospital email system; provide local educational lectures to family physicians; and attend the family practice monthly meetings to provide relevant updates.

Establish lines of communication

Once community needs are identified and the appropriate care team is chosen, family practices must establish lines of communication between providers. This involves transmitting relevant information about individuals and about programs in a timely, legible, relevant, and understandable manner. Communication may occur in person, by telephone, or by other means, including electronic medical records (EMRs).

EMRs are widely recognized as an essential tool to coordinate care, particularly for patients with comorbidities who may be seeing various health care providers for different health concerns. Physicians indicated that they are better able to share patient information with members of their team, whether on-site or remotely, when comprehensive, legible, and accurate patient histories are available.[13] Among other benefits, EMRs facilitate sharing information needed for referrals and consultations, and for teaching, conducting practice-based research, and evaluating the effectiveness of the practice as part of a commitment to continuous quality improvement.[1] EMRs are particularly beneficial when services are not co-located and members of the care team communicate remotely as a part of their community of practice. The Best Advice guide *Adopting EMRs in a Patient's Medical Home* provides practical advice for health professionals about what to consider when adopting an EMR system.

Case study: Effective communication

A family medicine unit (FMU) in Montreal, Quebec, has approximately 45 full-time and part-time staff. Staff members are divided into four teams; at least two members of these teams have a special interest in obstetrics.

To foster effective communication: members on the same team meet weekly; health care providers share the same EMR; patient appointments are scheduled on days when the multiple providers working with the patient are on-site; and members of the team are all present in the same teaching room while reviewing cases with trainees.

For instance, the personal family physician will follow a patient until about 30 weeks into pregnancy. If that personal physician does not practise intrapartum care, one of the family physicians who does takes over the patient care after 30 weeks. During the first and second trimesters, the personal family physician consults with the colleague as necessary, and both physicians monitor the progress of the pregnancy through the EMR. When the patient is in the labour and delivery room, the personal family physician is informed and will be contacted when she delivers. At that point, the personal family physician will visit the patient in the hospital and arrange the first postpartum visit, as well as the appointments for the newest patient of the practice.

Co-locate services in family practice settings

Some communities of practice, when capacity is available, choose to co-locate their services. That allows FPSIs and family physicians with focused practices to work together within a family practice setting to address the health care needs of people using those services. While helpful, co-location alone does not guarantee effective collaboration, without some of the elements previously listed.

Case study: Co-location

An FMU in Montreal, Quebec, established a musculoskeletal (MSK) clinic in the unit for the benefit of patients and trainees. The MSK clinic operates within the same clinical space, and consults are sent through the secretaries and requests for specific opinion can be answered within the same practice.

The family physician with a special interest in MSK problems evaluates the patient and prepares a written report. In some instances, it is a one-time visit to clarify or confirm a diagnosis. In other instances, a number of visits are required to help clarify the diagnosis (including organizing any required blood tests or imaging) or to identify a future course of treatment.

Patients benefit by having rapid access to a family physician with expertise in MSK problems in a familiar setting with a simplified booking process. In addition, the treating physicians benefit by receiving timely consultation reports, as well as the opportunity to improve their own MSK skills.

Participate in virtual communities

Co-location is not always feasible or necessary. At other times, family physicians in rural or remote regions may choose to connect virtually with colleagues who have enhanced skills. Virtual communities of practice allow family physicians to work together to provide resources and consultation services as needed. Technological advances and EMRs can be used effectively to maximize these collaborations.

Consult with other family physicians

Family physicians can connect with their colleagues when additional expertise is needed. This can take place in various ways, including:

- FPSIs offer advice, guidance, and follow-up to primary care providers to support care of patients and families
- Family physicians with focused practices provide support by connecting with the patient's own family physician and offering their services when needed

Within collaborative practice settings, it is important to define lines of accountability and establish pathways in which patients are referred to family physicians with added skills. Once patients have been seen by a family physician with added skills and/or a different scope of practice, their medical records should be updated and communicated so the entire care team is aware of any change to the treatment plan.

Case study: Consultation

A family practice in Northern Ontario has formed collaborative networks with FPSIs as part of the PMH. These collaboratives involve consultations with family physicians with an interest in obstetrics, as well as family physicians with an interest in addiction. The family physician can coordinate care and refer patients to family physician colleagues as needed while remaining involved in patient care. For example, for a pregnant woman, a family physician in this collaborative provides prenatal care, but not intrapartum care. The family physician contacts another physician who leads a family medicine obstetrics clinic at another site. The two agree to provide shared care for the patient. When the baby is born, the family physician will see the newborn at the office within 2–3 days.

Promote teaching and research in the PMH

Family physicians with added skills are encouraged to teach medical students, residents, and other learners, enriching the overall family medicine learning experience. Providing formal and informal learning to colleagues as part of their work can raise the overall knowledge base of the PMH team. A study exploring enhanced surgery skills for rural primary care providers in Canada identifies mentors and role models, particularly those with an initial family medicine background, as the most salient influencing factor in the trajectory of study participants pursuing advanced training.[14] It's important that CPFM practices that offer teaching opportunities actively promote the importance of generalism, integration with and strengthening of family medicine as a whole, and nurturing a sense of service and response to community need.

All family physicians within the PMH are also encouraged to participate in research. Those with special interests or enhanced scope of practice offer collaborative richness and perspective to the research team. In addition, academic centres and continuing education departments must prepare learners and practitioners to work in collaborative partnerships.[7]

Case study: Teaching and research

At an urban tertiary care hospital in Montreal, Quebec, a family physician's clinical work is solely in cancer care. This family physician's hospital duties include providing supportive oncology care to cancer patients undergoing treatments (ranging from symptom management to cancer treatments), psychosocial patient and/or family interventions, as well as end-of-life related care.

The family physician's main roles involve going into the community on a regular basis to teach primary care providers (PCPs) about common issues, surveillance needs, and up-to-date follow-up recommendations for cancer survivors. This family physician also shoulders the role of "expert resource provider" to community primary care providers, by providing prompt phone consultation advice for any inquiries PCPs may have about their patients with a cancer history. Moreover, along with nursing support, this family physician helps facilitate transition of care back to PCPs in the community, once tertiary care treatments are completed, through key standardized coordination interventions. Such interventions include empowering cancer survivors through educational activities, which promote the important role of PCPs in survivorship care delivery.

CONCLUSION

Communities of practice have an important role to play within the PMH. By establishing intraprofessional collaborations within family practice settings, family physicians can better address community needs and provide comprehensive care closer to home. Family physicians with special interests and those working in focused practices can use added skills to provide care to patients and empower their colleagues. Ultimately, it is the recipients' experience of care that must be seamless and leave patients feeling that their needs have been met. The CFPC remains committed to the importance of comprehensive continuing care. Additional scopes of expertise available within a PMH will depend on the needs of each community. Family physicians should continually assess those needs to ensure that their patients are receiving optimal care through collaborative partnerships in the PMH.

References

1 Wenger E. *Communities of Practice: Learning, Meaning, and Identity*. Cambridge: Cambridge University; 1998.

2 Endslay S, Kirkegaar M, Linares A. Working together: communities of practice in family medicine. *Fam Pract Manag*.

3 College of Family Physicians of Canada. *A Vision for Canada: Family Practice – The Patient's Medical Home*. Mississauga, ON: College of Family Physicians of Canada; 2011. Available from: www.cfpc.ca/uploadedFiles/Resources/Resource_Items/PMH_A_Vision_for_Canada.pdf. Accessed 2016 April 14.

4 Department of Health. Part 3: The accreditation of GPs and Pharmacists with Special Interests. In: *Implementing care closer to home: Convenient quality care for patients*. 2007. Available from: webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_074424.pdf. Accessed 2016 April 12.

5 Department of Health. Part 1: Introduction and overview. In: *Implementing care closer to home: Convenient quality care for patients*. 2007. Available from: webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_074426.pdf. Accessed 2016 April 6.

6 Leelavathi M. Family physicians with special interest in dermatology. *Malays Fam Physician. 2008;3(1):64-65.*

7 Kates N, Mazowita G, Lemire F, Jayabarathan A, Bland R, Selby P, et al. The Evolution of Collaborative Mental Health Care in Canada: A Shared Vision for the Future. *Can Journal Psychiatry*. 2011;56:B1-B10.

8 Endsley S, Kirkegaard M, Linares A. Working Together: Communities of Practice in Family Medicine. *Fam Pract Manag*. 2005;12(1):28-32. Available from: www.aafp.org/fpm/2005/0100/p28.html. Accessed 2016 April 6.

9 Soubhi H, Bayliss EA, Fortin M, Hudon C, van den Akker M, Thivierge R, et al. Learning and caring in communities of practice: using relationships and collective learning to improve primary care for patients with multimorbidity. *Ann Fam Med*. 2010;8(2):170-177. doi: 10.1370/afm.1056.

10 Swanepoel M, Mash B, Naledi T. Assessment of the impact of family physicians in the district health system of the Western Cape, South Africa. *Afr J Prm Health Care Fam Med*. 2014;6(1):e1-8. doi: 10.4102/phcfm.v6i1.695.

11 Starfield B, Shi L. The medical home, access to care, and insurance: a review of evidence. *Pediatrics*. 2004;113(Supplement 4):1493-1498.

12 Moosa S, Mash B, Derese A, Peersman W. The views of key leaders in South Africa on implementation of family medicine: critical role in the district health system. *BMC Family Practice*. 2014;15:125. doi: 10.1186/1471-2296-15-125.

13 PricewaterhouseCoopers. *The emerging benefits of electronic medical record use in community-based care*. Toronto, ON: Canada Health Infoway; 2013. Available from: http://www.pwc.com/ca/en/healthcare/publications/pwc-electronic-medical-record-use-community-based-care-report-2013-06-en.pdf. Accessed 2016 June 17.

14 Kornelsen J, Iglesias S, Humber N, Caron N, Grzybowski S. GP Surgeons' Experiences of Training in British Columbia and Alberta: A Case Study of Enhanced Skills for Rural Primary Care providers. *Can Med Educ J*. 2012;3(1):e33-41. eCollection 2012.