Family Care Teams

A Health Policy Framework for Newfoundland and Labrador

Family Care Team

Newfoundland & Labrador

Table of Contents

List of Abbreviations

CAC - Community Advisory Committee

CFPC - College of Family Physicians of Canada

CHA - Community Health Assessment

CIHI - Canadian Institute for Health Information

CSS - Community Support Services

CQI - Continuous Quality Improvement

CRMS - Client Referral and Management System

CSC - Collaborative Services Committee

CSSD - Department of Children, Seniors and Social Development

EMR - Electronic Medical Record

FP - Family Physician

FPN - Family Practice Network

FPRP - Family Practice Renewal Program

FTE - Full Time Equivalent

HANL - Health Accord NL

HCP - Health Care Provider

HCS - Department of Health and Community Services

HIS - Health Information System

IGOs - Indigenous Governments and Organizations

IPC - Inter-Professional Collaboration

LHSS - Learning Health and Social System

MHA - Mental Health and Addictions

MOA - Memorandum of Agreement

MCP - Medical Care Plan

MRP - Most Responsible Provider

MUNL - Memorial University of Newfoundland and Labrador

NLHS - Newfoundland and Labrador Health Services

NLMA - Newfoundland and Labrador Medical Association

NP - Nurse Practitioner

ODT - Opioid Dependence Treatment

OPED - Office of Professional Education and Development

PCNL - Patient Connect NL

PCP - Primary Care Provider

PH - Public Health

PHA - Population Health Assessment

PHC - Primary Health Care

PHIA - **Personal Health Information Act**

PHPRRO - Provincial Health Professional Recruitment and Retention Office

PHR - Personal Health Record

PMH - Patient's Medical Home

QCNL - Quality of Care NL

RN - Registered Nurse

SDH - Social Determinants of Health

SHN - Strategic Health Network

Intended Audience

Family Care Teams: A Health Policy Framework for Newfoundland and Labrador is intended for those involved in the planning, implementation, ongoing service delivery, performance monitoring and evaluation of Family Care Teams in Newfoundland and Labrador.

For affiliated practices, this framework is complemented by an affiliation agreement that may affect the terms and conditions of an affiliated practice's relationship with a Family Care Team. Individuals connected to an affiliated practice are encouraged to review the terms of the affiliation agreement in connection with this framework. For more information, see Linkages to Other Practices, Part II, A page 43.

Purpose

Within this policy framework, the Department of Health and Community Services (HCS) sets out the key provincial policy directions and expectations for Family Care Teams as a cornerstone component of a transformed primary health care (PHC) system for Newfoundland and Labrador.

What is a Family Care Team?

Family Care Teams are an innovative approach to re-imagine and re-design the health system in Newfoundland and Labrador. Family Care Teams aim to improve access and continuity of primary health care (PHC) for individuals and families in their community. They represent a significant shift from solo-based community practice and program-based models of service delivery to an inter-disciplinary team-based model. Family Care Teams offer seamless access to multiple health care professionals that focus on meeting the health and social needs of individuals and families.

PHC is typically a person's first point of contact with the health care system. It encompasses a range of community-based services essential to maintaining and improving overall health and well-being throughout an individual's entire lifespan. It recognizes that health is a state of complete physical, mental and social well-being and is not merely the absence of disease or infirmity. PHC is also a philosophy for organizing and delivering a range of coordinated and collaborative community-based services that empower individuals, families, and communities to take responsibility for their health and well-being. Effective PHC requires a culture and system designed to be responsive to individual and population health needs.[2]

Family Care Teams provide **a framework to reorganize and expand on existing community-based health services** and to modernize and increase the adaptability and agility of the Newfoundland and Labrador health care system. Importantly, they respond to the dynamic and diverse needs of the population and are an innovative solution to address challenges in delivering PHC. These include: recruitment and retention of health care providers (HCP), limited access and continuity of care for individuals and their families, efficient use of fiscal resources and system sustainability, and addressing the factors that influence health the most – the social determinants of health (SDH).

This framework outlines the key attributes, principles, general planning and implementation expectations, and considerations for the integration of Family Care Teams in Newfoundland and Labrador. This framework also shines light on an opportunity to train a variety of HCPs within Family Care Teams across the province who will be well equipped to provide team-based care upon their graduation. Moreover, having learners embedded in PHC practice increases the quality of care provided.

Introduction

The vision for Newfoundland and Labrador Family Care Teams is to give every person in the province timely access to health and social services, and to continuous care centred in the community as part of a well-connected network. This includes providing an innovative working environment that attracts HCPs and allows them to flourish by supporting and promoting their professional growth, satisfaction, and well-being. Family Care Teams will be enabled and strengthened by inter-professional teams working collaboratively, with individuals and their families, to focus on all aspects of health and wellness. This will lead to greater stability and sustainability of the PHC system.

The current community health care system in Newfoundland and Labrador has many existing strengths. These include effective programs with dedicated HCPs, which together provide a foundation for the transition to Family Care Teams. The integration of existing NL Health Services (Newfoundland and Labrador Health Services) programs and services (e.g., Primary Care, Mental Health and Addictions (MHA), Community Support Services (CSS), Public Health (PH), and community-based practices (e.g., family physicians (FP), allied health professionals, and pharmacists), are critical components of transforming and rebalancing the Newfoundland and Labrador health system. In implementing Family Care Teams, there will also be engagement with Indigenous governments and organizations (IGOs) regarding linkages with the community health services they provide, and connections with other community services and supports.

What Services are included in a Family Care Team?

Family Care Teams include:

- Family Physicians
- Nurse Practitioners
- Clinical and Social Navigators
- Nurses (Registered Nurses, Licensed Practical Nurses)
- Manager and Clinical Director (physician)
- Practice Improvement Leaders/ Practice Facilitation Coaches
- Administrative/Clerical Support

Based on needs and available resources, Family Care Teams will also have the following providers:

- Allied Health Professionals (Physiotherapy, Occupational Therapy, Speech Language Pathology)
- Pharmacists
- Social Workers
- Public Health Nurses
- Psychologists
- Community Health Nurses
- Others including Learners

A Family Care Team will have clear pathways to connect and/or integrate with:

- Community-based practices (physicians, allied health, pharmacists, etc.)
- Community para-medicine
- 23 Health Centres
- Indigenous Governments and Organizations

A Family Care Team will have linkages to:

- Academic Institutions
- Social and Health Networks
- Schools, municipalities, community organizations/groups
- Provincial Health Authority programs

The Family Practice Renewal Program (FPRP) was established in 2015, through Schedule J of the MOA between the Government of Newfoundland and Labrador and the Newfoundland and Labrador Medical Association (NLMA), as a key strategy for PHC reform. The FPRP has several components including Family Practice Networks (FPNs), a Practice Improvement Program and a Fee Codes program. Collaborative Services Committees (CSCs) are mandated within Schedule J as a mechanism for FPNs and Newfoundland and Labrador Health Services to collaborate on initiatives to improve the health system and health outcomes. The work of CSCs to date will be leveraged to support integration of FPNs within planning, implementation, ongoing performance monitoring and evaluation of Family Care Teams. To date, many successful initiatives and outcomes can be attributed to the FPRP implementation in Newfoundland and Labrador[3]. These experiences and associated learnings, along with medical education, can be leveraged for supporting successful Family Care Team implementation in Newfoundland and Labrador.

As we advance the transition to Family Care Teams, we are propelling forward the system shift to team-based care as outlined in Healthy People, Healthy Families, Healthy Communities: A Primary Health Care Framework for Newfoundland and Labrador 2015-2025 and Health Accord for Newfoundland and Labrador (HANL). We are also adopting key approaches and principles as outlined in the Patient's Medical Home (PMH) model developed by the College of Family Physicians of Canada (CFPC). Each of these strategic resources include a focus on connecting individuals and families to collaborative, inter-disciplinary, health teams as part of PHC system reform. The vision of HANL is to improve health and health outcomes of Newfoundlanders and Labradorians through acceptance of and interventions in the SDH, and a higher quality health system that rebalances community, hospital, and long-term care services over a ten-year timeframe. In its final report, HANL recommended approximately 35 community teams, as an effective, provincial PHC service delivery model to cover the entire geography of Newfoundland and Labrador (substantively along the lines of Appendix A). There are proven benefits to a team-based approach in PHC[4]. Benefits include achieving better outcomes, satisfying needs, ensuring continuity of care, increasing job satisfaction among HCPs, reducing health care costs, and using health human resources more efficiently.

High quality, community-based PHC is foundational to rebalancing the health system, improving health outcomes and increasing access to underserved populations and communities. It is imperative that we deliver care in a culturally appropriate way that addresses gaps in social, economic and geographic disparity. Without adequate access to PHC interventions, health outcomes are poorer (e.g., higher rates of chronic diseases and deaths) and there is increased strain and reliance on more costly, and less appropriate parts of the health care system (i.e., emergency departments and acute care). Family Care Teams provide wrap around community-based access to an inter-professional team that promotes health and prevents, detects, diagnoses, treats, and manages chronic conditions while addressing the SDH.

Newfoundland and Labrador's Family Care Teams will be as unique and diverse as the geographical locations and the needs of the populations they serve. Therefore, they will need to be inclusive, flexible and responsive. While all teams will have similar core features, they will be co-designed with providers and communities using needs- and strengths-based planning approaches. Each team will be co-led by a team manager and a clinical leadership role who will use data driven approaches and regularly engage with community providers and stakeholders to ensure services are responsive to needs. Patients and families will be connected to a most responsible provider (MRP) on the team, who will coordinate their care, with access to a range of multi-disciplinary services and supports.

Critical to realizing successful transformation to Family Care Teams will be creating and defining new team roles, clarifying and realigning existing roles, outlining primary responsibilities and accountabilities, maximizing scope of practice of all Family Care Team providers, and applying change management strategies (refer to Appendix B). Roles and responsibilities can be found throughout this document and in applicable legislation, professional standards of practice or Memorandum of Agreement (MOA) documents; however, work remains to succinctly outline the roles of Family Care Team members in the Newfoundland and Labrador context. These Family Care Teams will also be teaching teams. As we move forward, we will also ensure key stakeholders continue to be engaged in various aspects of developing, supporting and governing Family Care Teams.

"Part I" of this framework focuses on critical attributes of Family Care Teams, which are foundational to the success of this health transformation. Each section of "Part I" includes a description and primary goal(s) and key objectives. "Part II" offers planning and implementation considerations for Newfoundland and Labrador Health Services, along with associated stakeholders. Documents and resources including the HANL (the Report[5] and Blueprint[6]) and the CFPC PMH Model[7] provide additional reference information and critical context to support transformation.

Further consideration must be given to other significant aspects of provincial health policy and system change that are interconnected with Family Care Teams but fall outside the scope of this policy framework (e.g., the Social Well-Being Plan led by the Department of Children, Seniors and Social Development [CSSD], and implementation of other HANL Calls to Action). This framework will be a living document to which other components can be added as Family Care Team work advances. The full and successful integration of health and social programs and services, as outlined in the vision, will take time, resources, and sustained engagement over the coming years.

Part 1 Attributes of Family Care Teams

A. Governance and Leadership

Family Care Team Provincial Steering Committee

Primary Health Care Strategic Health Network

35 Family Care Team Leadership Committees

Effective governance and leadership is integral for the success of Family Care Teams. This is critical for setting long-term strategies, implementation milestones, and direction for operational activities. Leadership and governance structures support teams in establishing priorities, stakeholder relations, teaching and learning arrangements, policies, procedures, roles, responsibilities, effective communications and evaluation plans. Conflict resolution, human resource planning, team building and cohesion, change management, and routine administrative tasks are also supported by a functional, efficient, and inclusive internal governance structure.

Individual providers within Family Care Teams will consist of HCPs functioning under diverse regulatory bodies, professional standards of practice, remuneration models, and licensing arrangements. They may be employees of Newfoundland and Labrador Health Services or community-based practices that are formally affiliated with the Family Care Team. Given such diversity, without an effective governance and leadership structure, a group of providers may be challenged to come together as a high-functioning Family Care Team. Establishing a shared vision of person-centred care, governance around clinical data sharing, change management and team building concepts will be critical components of transitioning to team-based care. Governance structures will require significant engagement and inclusion of key stakeholders and include patient and family experience from the beginning. Together, these features will lay a foundation that enables teams to work cohesively and effectively.

It is imperative that all key stakeholders see themselves in the governance structure for Family Care Teams. These include, but are not limited to, Newfoundland and Labrador Health Services, FPRP, affiliated practices, professional associations, colleges, social services organizations, IGOs, as well as public interest groups. Each local region and team is distinct, with its own unique features and requirements. To reflect these variations, leadership within the Family Care Teams must be flexible in format and approach.

In some cases, significant work has begun on governance structures between partners, which provides opportunity for early learnings to bring to the new structures and create stronger partnerships and relationships to support the new vision for Family Care Teams in Newfoundland and Labrador.

Family Care Teams Governance Structure

A shared leadership model will be used for the governance of Family Care Teams. To ensure the long-term vision for transformation to Family Care Teams is realized and sustained, three committees will form the governance and leadership structures. These committees will ensure the accountability and engagement of local providers, provincial stakeholders, IGOs, as well as the broader communities in which Family Care Teams exist. The governance structure for Family Care Teams is as follows:

1. Family Care Team Provincial Steering Committee

Reports/Accountable To: Minister of Health and Community Services

Purpose: To ensure realization of the shared long-term vision for Family Care Teams by strategically aligning funding, resources, and other enablers of Family Care Teams and by monitoring progress. This committee will oversee the establishment of a Family Care Team Provincial Implementation Plan, priorities and key milestones, and identify issues and required changes to ensure operational success of the Family Care Team vision.

2. Primary Health Care Strategic Health Network (SHN)

Reports/Accountable To: Family Care Team Provincial Steering Committee /Newfoundland and Labrador Health Services Health Advisory Council

Purpose: To oversee the implementation and evaluation and support the sustainability of the Family Care Teams.

The Strategic Health Network (SHN) is a forum for integration of family care teams on a provincial scale. It supports engagement and collaboration with a wide range of stakeholders that will champion change, contribute perspective and insights and support alignment. The SHN will ensure the involvement of all key stakeholders, support all aspects of teams, ensure inclusion of community-based practices, and guide the vision and provincial operationalization of Family Care Teams as per the policy framework. The SHN will prioritize inter-professional collaboration (IPC) through utilization of existing health and social resources in Newfoundland and Labrador Health Services (i.e., the integration of MHA, CSS, and PH) and the community, through emphasis on transformation and change management. The SHN will ensure Family Care Team enablers are operationalized.

3. Family Care Team Leadership Committee (local area level)

Reports/Accountable To: Chief Operating Officer/ Strategic Health Network

To establish a shared vision and undertake the required planning and implementation of a team approach for each Family Care Team.

The Family Care Team Leadership Committee will establish a high functioning Family Care Team which fosters partnership and provides opportunities for collaboration across services, programs, and practices to support the health and social needs of all connected individuals and families.

Family Care Teams will have various combinations of salaried providers, including the integration of Newfoundland and Labrador Health Services community programs and services, and community-based providers (through affiliation agreements). Each Family Care Team requires a leadership committee structure that engages providers and ensures the Family Care Team meets their outlined goals.

Dedicated Family Care Team Managers with core competencies defined to support successful implementation and sustainability of the Family Care Teams, will play a key leadership role for the team and will be accountable for health transformation within each of the geographical areas. These positions need to be fully dedicated to the local Family Care Team. These managers will work closely with clinical leadership as well as Newfoundland and Labrador Health Services program managers that integrate within Family Care Teams to ensure program integrity through Family Care Team participation.

In previous PHC frameworks, FP leadership has been highlighted as a foundational component to collaborative team-based PHC. Each team will identify a Clinical Director/Physician lead who will play a critical role in linking with community FPs, through existing FPN/CSC structures and by creating new mechanisms as needed. The Clinical Director/Physician will also provide clinical oversight of the Family Care Team and help ensure that clinical services delivered by the team are meeting the needs of the population. Moreover, they will be responsible for overseeing health education delivery for their team. Nurse Practitioner (NP) led clinics will also be a key feature of the Newfoundland and Labrador Family Care Team model; as such, NP leadership will be considered in the governance team (see Models of Service Delivery).

Where a family physician is connected to a Family Care Team through an affiliated practice and the family physician takes on a leadership role within the Family Care Team, the family physician will be accountable to the Chief Operating Officer/Strategic Health Network for the leadership role in accordance with the governance framework outlined in this framework.

Attribute Goal: An effective governance and leadership structure to support Family Care Teams.	
Attribute Objectives:	**Responsible Governing Bodies**
Create terms of reference and establish the outlined governance and leadership structures.	HCS/NL Health Services
Establish a Provincial Implementation Plan for Family Care Teams.	HCS/NL Health Services
Identify a Manager/Leader role for each Family Care Team, with a common provincial position description.	NL Health Services
Identify a Clinical Director/Physician Leadership role for each Family Care Team, with a common provincial position description.	NL Health Services
Ensure the utilization of existing Newfoundland and Labrador Health Services resources are supported at all levels of governance, and particularly, at the team level through application of change management strategies.	HCS/NL Health Services

B. Inter-Professional Collaboration

As PHC needs become increasingly complex, a collaborative team-based approach becomes even more important. IPC is the process of problem-solving, sharing responsibility for decision-making, and carry out a care plan while working towards a common goal. Clinical outcomes and quality of services improve when HCPs work together toward shared goals that focus on the individual. Collaborative team-based PHC is particularly effective for patient care through management and prevention of chronic disease, providing care for people with complex needs, meeting the needs of the aging population, and providing mental health and addictions care.

Practicing within a collaborative team, where providers complement each other, also benefits HCPs. They describe the positive experience of working with colleagues, opportunities for gaining enhanced knowledge and skills, and greater efficiency. Providers report improvements in practice patterns including referrals, patient follow-up, care coordination, documentation, communication, and reduced duplication of effort. IPC in PHC also has positive impacts on the health system. Improved access and better quality care are linked to fewer admissions, and shorter lengths of stay. Other benefits to the health system include reduced costs, fewer people not attached to a primary provider, more efficient use of space, and improved provider recruitment and retention.

Strategic and intentional effort are required for a group of HCPs to transform into a high-functioning Family Care Team. This may take time, and facilitation may be necessary to help a group of individual providers become a cohesive team. To work together effectively, PHC professionals must see themselves as a team and engage collaboratively as they provide care. This requires effective communication, typically through shared electronic record keeping; a supportive governance structure and organizational environment; and, a thorough understanding and acceptance of each other's professional roles.

Attribute Goal: Inter-Professional Collaboration is the foundation of Family Care Teams.	
Attribute Objectives:	**Responsible Governing Bodies**
Dedicate time to develop a shared vision.	NL Health Services
Ensure the organizational environment supports IPC.	NL Health Services
Define roles and responsibilities of each provider.	NL Health Services
Provide role clarity to ensure each team member understands and respects their own, and each other's, professional role and scope, and work towards complementing each other.	NL Health Services
Provide structured learning opportunities to develop IPC competencies, enable the development of a common language and provide a launching point for teams shifting to collaborative practice.	NL Health Services
Establish mechanisms for communication, referral, and strategy with relevant community-based practices, stakeholders, and organizations.	NL Health Services
Establish a communication platform to enable collaboration where team members and their roles are easily identified and accessible.	NL Health Services
Work with Memorial University of Newfoundland and Labrador (MUNL) and other academic institutions to support continued professional education within Family Care Teams.	HCS/NL Health Services/MUNL
Engage Indigenous partners in creating formal and informal structures for IPC as needed.	NL Health Services
Develop a web-based platform for team-based education that includes learning pathways, IPC, CQI, and change management.	HCS/MUNL/Quality of Care NL (QCNL)/ Office of Professional and Educational Development (OPED)
Engage quality improvement leaders and practice facilitators as needed.	HCS/MUNL/QCNL/OPED
Evaluate IPC within Family Care Teams.	NL Health Services

C. Social Determinants of Health

The SDH are the social, economic, and environmental factors that influence health outcomes[9]. The SDH are the conditions in which people are born, grow, work, live, age, and the systems that shape an individual's daily life. The SDH have an important influence on health, and health inequities – the unfair and avoidable differences in health status of individuals. In Newfoundland and Labrador, not unlike many other places globally, health and illness follow a social gradient: the lower the socioeconomic position, the worse health. HANL embraces the integration of SDH and their role within our health system and their fundamental importance to improving health outcomes. To address the SDH in the Family Care Team setting, stakeholders must first acknowledge that health is related not only to health care but also to human biology, the environment, and lifestyle. There are a growing number of clinical tools to help HCPs engage individuals about the SDH.[10,11,12] IGOs have an important role to play with respect to promoting understanding of the unique SDH of Indigenous populations (e.g., the social determinants of Inuit health[13]). Social Navigators should understand the social, historical and cultural contexts of the SDH that affect Indigenous populations.

Social Navigators will be embedded in Family Care Teams to develop pathways that enable transitions in care and partnerships to address the SDH. Social Navigators will have training to recognize, assess, record, and intervene in all areas of the SDH and will link with appropriate resources (e.g., within the Family Care Team, relevant government departments, and community-based services like 211). Connecting people with resources and ensuring that appropriate transitions in care and subsequent follow-up takes place is critical to the success of addressing the needs of individuals and families in a holistic manner.

The members of the Family Care Team all need education and training on the significance of SDH and on how to address them in a Family Care Team environment. To be effective in the long-term, Family Care Teams have a role in addressing the SDH beyond individual care. Family Care Teams will need strong linkages to provincial programs (e.g., PH) to ensure SDH at the population health level are addressed as well. Evaluation of Family Care Teams must include individual and population level metrics. This data will be shared with relevant government departments and the community to inform future policy and actions that support the broad vision of Family Care Teams.

Attribute Goal: Interventions and approaches to address the social determinants of health are integrated into Family Care Teams.	
Attribute Objectives:	**Responsible Governing Bodies**
Pilot social prescribing (referring people to a range of non-clinical services) to make further links between SDH and health outcomes.	HCS/CSSD/NL Health Services/FPRP
Provide education and curriculum for HCPs about addressing health equity and the SDH at the individual and population level.	HCS/NL Health Services/MUNL
Recruit and integrate Indigenous navigators to work alongside other HCPs where appropriate.	NL Health Services
Develop pathways to enable referrals and partnerships with community programs.	NL Health Services
Proactively assess SDH as part of an initial assessment for care management and social barriers to care. Introduce methods for collecting data on the SDH.	NL Health Services
Engage PH, as needed, to lead connections with community agencies and organizations related to SDH (e.g. schools, local food banks, municipal governments, transportation networks).	NL Health Services
Engage IGOs to identify potential SDH barriers and solutions.	NL Health Services
Provide population health promotion and SDH interventions within geographical team areas.	NL Health Services

D. Integration and Navigation

Integration

Community team-based care is a key characteristic of effective and integrated health systems. It has promise to improve the following: population health and individual health outcomes enabled via continuity of care; appropriate use of resources; timely access; chronic disease management; client and provider satisfaction; and provider work-life balance. Further, it has potential to relieve the burden on emergency rooms throughout Newfoundland and Labrador, reduce hospitalizations, reduce costs, decrease referrals to other providers and fragmentation of care, encourage care at home, and support aging in place.

Integration goes beyond the care provided within a Family Care Team and addresses care provided across the entire health care continuum, including the harmonization and partnership with community-based practices and well developed pathways and protocols to access secondary and tertiary health centres across Newfoundland and Labrador when needed.

Integration of existing community health providers and programs can break down silos in our current system. Re-alignment of existing community health program-based services into Family Care Teams is critical to ensure that person-centred, coordinated care is delivered by the most appropriate providers, in accessible settings. All health care professionals in a health care team provide a specific skill set and knowledge that are valuable to person-centred care. As such, the objectives of a high-functioning Family Care Team include supporting the flow of information across and between providers and patients.

Imperative to building and strengthening well-integrated Family Care Teams is dedicated leadership and change management resources for the transformation to a rebalanced and integrated health care system. Clear roles and responsibilities and expanded scope of practice are essential to improving care and inter-professional team success. Full integration, as outlined in the vision for Family Care Teams, will take time, resources and dedicated leadership with change management support.

Attribute Goal: All residents of Newfoundland and Labrador are connected to primary health care services that are linked to a full continuum of health care services.	
Attribute Objectives:	**Responsible Governing Bodies**
Create approximately 35 Family Care Teams to cover the entire provincial geography in Newfoundland and Labrador (see Part II for planning details).	HCS/NL Health Services
Integrate care with a variety of HCPs including: FPs, medical learners, NPs, nurses, pharmacists, allied health professionals, mental health supports, dentists, occupational therapists, physiotherapists, chiropractors, dietitians, social workers, public health nurses, community health nurses, and other providers as needed.	NL Health Services/IGOs
Integrate existing Newfoundland and Labrador Health Services and Indigenous community health services into teams as appropriate (e.g. MHA, CSS, PH).	NL Health Services/IGOs
Develop new arrangements (i.e., affiliation agreements) to connect existing community-based practices (e.g., family practices, allied health and pharmacies) with Family Care Teams.	HCS/NL Health Services/ Professional Associations/ Community-Based Practices
Develop transfer medicine policies and protocols, and implement required system resources (e.g., transport services) to ensure rural and remote Teams are able to escalate care for patients requiring management at secondary and tertiary centres.	NL Health Services
Enable effective team communication and sharing of clinical information to support person-centred care through the following: education, change management, digital infrastructure, and data governance.	HCS/NL Health Services
Ensure effective communication pathways exist between hospital and community at intersections of care and points of transfer, especially hospital admission and discharge.	NL Health Services

Navigation

Understanding how to navigate the health system is critical to receiving appropriate and optimal care. Clear pathways to care are needed to help reduce barriers, inefficiencies, and duplications in care. Currently, most navigation positions within the provincial health care system are related to a specific chronic condition/program (i.e., cancer care, MHA) or population (i.e., vulnerable and/or underserved groups). The most common responsibilities of health system navigators are facilitation and coordination of care, assisting with appointment scheduling and other logistical support (e.g., medical transportation, health insurance applications, etc.). Indigenous Patient Navigators also support providers with education about culture, thereby increasing cultural awareness and competency in the health workforce.

Social Navigators, as mentioned in Part I, Section C, will be part of Family Care Teams. They will work alongside other Family Care Team members to support people with social issues affecting their health and connect them with needed resources. These roles are typically consistent with the education and professional scope of practice of registered social workers or social service workers. The Family Care Teams will also include a Clinical Navigator position to ensure a person cared for by the team is supported across the continuum of health care. These positions are typically Licensed Practical Nurses or Registered Nurses (RNs).

To address gaps in the current system, navigation services will be an integrated component of the Family Care Teams. Navigation support may include individualized care planning, identifying care pathways, providing health literacy support and digital access to care information, and facilitating shared decision-making. Navigation support in rural parts of the province is particularly important given the unique challenges that residents face with accessing PHC and other health care services. Valuing person-centred care and experience, including the commitment to improve access, transitions, and coordination, will be a cornerstone of Newfoundland and Labrador Family Care Teams.

Attribute Goal: Care is coordinated across health and social systems by enhanced communication and system navigation.	
Attribute Objectives:	**Responsible Governing Bodies**
Develop and establish Clinical and Social Navigator roles early into Family Care Teams. Include other navigation roles as needed.	NL Health Services
Link to and/or establish centralized and accessible web-based sources of information for individuals and families that clearly specify available supports and resources (e.g., Bridge the gapp; 211).	NL Health Services
Empower people to make decisions using their health information (e.g., supporting digital access to the Personal Health Record (PHR)).	NL Health Services
Ensure navigators are trained to provide logistical support and broker required resources for patients (e.g., transfer/transport medicine, medical transportation, health insurance applications, Newfoundland and Labrador Prescription Drug Program, etc.).	NL Health Services

E. Access to Care

Accessibility of Family Care Teams for all residents of the province is a provincial priority. Access is the ability to receive health care services including prevention, diagnosis, treatment, and management of any health-impacting conditions. In order for care to be considered accessible, the following criteria should be considered: affordability, availability, accessibility, accommodation, and acceptability.

Newfoundland and Labrador's widely dispersed population includes many rural and remote communities. This creates unique challenges in accessing PHC. Addressing geographical disparities is integral to maximizing access to PHC services across Newfoundland and Labrador. Vulnerable populations also face inequities in access to care. Such populations include Indigenous people, persons with disabilities, aging seniors, persons living with mental illness or addictions, persons who are gender diverse, persons who live in poverty or isolation, refugees, immigrants, or those who require perinatal health care. Understanding people's lived experience and how it affects their access to health care is essential to reshaping our health care system in a way that is meaningful, increases quality of life, health outcomes as well as access to care in an inclusive and equitable way. Organizations with expertise in the care of populations, including persons with disabilities, persons who are gender diverse, refugees, immigrants, and Indigenous peoples, should be leveraged. Also, see Operational Expectations for Access to Family Care Teams.

Attribute Goal: All Newfoundlanders and Labradorians will have the opportunity to access primary health care through Family Care Teams.	
Attribute Objectives:	**Responsible Governing Bodies**
Communicate Family Care Team development updates and access information to the public at provincial, regional and local levels.	NL Health Services
Enable virtual capabilities of Family Care Teams for persons and providers (see Part I, Section H).	NL Health Services
Enhance Patient Connect Newfoundland and Labrador (PCNL) services and use data to connect citizens to a PHC provider, including Family Care Teams and community-based practices.	HCS/NL Health Services
Enhance the use of Hub and Spoke Models (see Part II, Section A (3)).	NL Health Services
Develop Family Care Team mobile clinics and provincial outreach capacity where primary care providers (PCPs) can travel to specific areas of the province to provide access.	NL Health Services

F. Continuity of Care

The MRP typically refers to the physician, a NP, or other regulated HCPs, who holds the overall responsibility for directing and coordinating the care and management of an individual at a specific point in time[15].

Continuity refers to the ongoing relationship between a person, their MRP, and their Family Care Team (See Appendix C for additional details). Evidence shows that individuals who consistently see the same providers are more satisfied, have better health outcomes, and have lower care costs. Continuous care allows providers to better understand an individual's unique health and wellness needs, and supports the development of a trusted relationship.

Continuity is especially important in PHC, where prevention and management of chronic conditions accounts for a significant piece of daily work. Chronic care is of particular concern, as chronic diseases are widespread and often poorly controlled. A continuous relationship with a MRP allows for HCPs and individuals to develop a trusting relationship. Continuity of care may be interrupted for many reasons, such as provider availability, the urgency of a health issue, limitations in a provider's skills and scope of practice, or by an individual's personal choice. No single provider can offer all aspects of PHC at all times. Operating procedures will be developed for when substitutions or supplementation is necessary.

Formal attachment between people and their MRP and PCP supports, but does not guarantee, continuity. An individual may be formally attached to a MRP, PCP, and Family Care Team, but if the access and quality of services provided does not meet their needs, they may seek care elsewhere such as a walk-in clinic or emergency department. People are more likely to seek out and maintain attachment relationships when Family Care Teams offer satisfactory access to services. This may include a variety of strategies such as walk-in services, same-day access, evening and weekend appointments, home or group visits and virtual care including telehealth, remote patient monitoring, and/or telephone advice.

Attribute Goal: Residents become rostered to a Family Care Team and attached to a primary care provider.	
Attribute Objectives:	**Responsible Governing Bodies**
Identify an individual's MRP within their Family Care Team.	NL Health Services
Utilize standard definitions of MRP, attachment, panel and roster (Appendix D)	HCS/NL Health Services/FPRP/ NLMA
Validate the relationship between an individual and their PCP at every health encounter.	NL Health Services
Incorporate panel management practices into daily operations, according to best practices.	NL Health Services/FPRP/ Community Family Practices
Maintain attachment information for every person-to-provider relationship.	NL Health Services
Designate a team member to complete regular panel management including up-to-date attachment status for every individual.	NL Health Services
Consider development of a Newfoundland and Labrador Provincial PHC Panel Management Toolkit.	HCS/NL Health Services/FPRP

G. Active Community Engagement

Engaging communities goes beyond traditional consultation methods and instead focuses on active participation of community members in the design process, and working with communities to build community health resilience. Community health resilience is "the ability of a community to use its assets to strengthen PH and health care systems and to improve the community's physical, behavioural, and social health to withstand, adapt to, and recover from adversity."[16] Resilient communities promote physical, behavioural, and social health. They are socially connected, have accessible health systems, withstand adversity, and foster community recovery. Newfoundland and Labrador's vision for Family Care Teams places value on strong linkages between communities and Family Care Teams.

People living within communities are aware of local needs, and have the best understanding of their community's assets, skills, and strengths. By engaging residents, health and social services are re-designed based on population needs specific to the local area, allowing resources to be directed towards the issues of greatest importance to the people. Throughout the community engagement process, it is imperative that the perspectives of Indigenous peoples and communities and those with lived and living experience are heard. This model ensures transparency of process and adoption of potential changes to services. When needs exceed resources and difficult decisions are necessary, they are more readily accepted when endorsed by trusted community members who have participated in the decision-making process.

To take advantage of community knowledge and insight, jurisdictions in Canada, and internationally, have developed tools for facilitating community engagement. Examples include: guidance for the establishment of Community Advisory Committees (CACs); conducting Community Health Assessments (CHAs); Population Health Assessment (PHA); using toolkits for carrying out town hall sessions, surveys, focus groups, and key informant interviews; and templates for establishing dialogue with community groups. The establishment of a CAC is a key step towards facilitating meaningful involvement of community members in the design and delivery of local PHC services. To enable consistency, a set of provincial guidelines for the establishment and operation of a CAC have been developed. Engaging with existing Wellness Coalitions and soon to be established well-being networks will be important community networks for Family Care Teams.

Family Care Teams can also take advantage of the CHA process to understand and monitor community composition and assets. The CHA process may reveal unique features and strengths and help to identify challenges and opportunities to enhance local services. PH also leads the PHA, which can provide valuable information to the Family Care Team. Aside from defined structures and processes such as CACs and CHAs, research also supports Family Care Teams using informal mechanisms of community engagement.

Attribute Goal: Mechanisms are in place to engage communities and citizens in the co-design and continuous quality improvement of Family Care Team service delivery.	
Key Objectives:	**Responsible Governing Bodies**
Participate in CHAs and PHAs as per the current Newfoundland and Labrador Health Services policy.	NL Health Services
Establish/realign a CAC within each Family Care Team service area as per the provincial CAC guidelines.	NL Health Services
Develop formal mechanisms to ensure information sharing between Family Care Teams, CACs and CSCs to help improve PHC delivery.	Family Care Team Governance Committees
Actively engage CACs, non-profit organizations, and Indigenous leadership.	NL Health Services
Identify opportunities for collaboration with community on health promotion, and chronic disease prevention activities.	HCS/NL Health Services/CSSD
Develop an integrated approach to public engagement within the new Family Care Team structure.	NL Health Services

H. Digital Technology

Digital and virtual technology, along with specific data, are identified as key enablers to Family Care Team success. Evidence exists that outlines the benefits to both providers and patients when access to patient data and associated synchronous and asynchronous processes are in place. Digital technology is a way to enhance access to primary care and add resources that can be leveraged by providers and patients to enhance care (for additional details see Appendix D).

HCS has key strategic large-scale technology and data strategies in progress that will enable Family Care Team digital technology and data requirements. They include the following:

- Health and social data governance framework
- Statutory review of the Personal Health Information Act (PHIA)
- Modernization and consolidation of the Health Information System (HIS)
- Rollout of the initial phase of the PHR
- Modernization plan for Client Referral and Management System (CRMS)
- Virtual Care policy along with the implementation of a provincial virtual care program
- Broadband enhancements throughout Newfoundland and Labrador, working with Department of Transportation and Infrastructure on this work

Attribute Goal: All Family Care Teams are equipped with the required digital and virtual technologies.	
Attribute Objectives:	**Responsible Governing Bodies**
Onboard Family Care Teams to the Electronic Medical Record (EMR)/ HEALTHe NL.	NL Health Services
Ensure digital solutions are available to capture health and social data at the point of care.	NL Health Services
Share data across and enhance digital processes between Family Care Teams and/or community-based practices (through policy and the appropriate technology).	NL Health Services
Enhance digital processes from Family Care Teams to health centres for services such as referrals, laboratory and diagnostic imaging services, along with prescribing to community pharmacies.	NL Health Services
Develop digital solutions to support referral decision-making and referral processes to specialist care.	NL Health Services
Avail of digital solutions capable of person-centred interactions (i.e., appointment booking, secure messaging with Family Care Team members, persons accessing their own health record).	NL Health Services
Enable digital solutions to collect the data required for analytics and performance monitoring (per Part I, Section I).	NL Health Services
Develop aggregate information from Family Care Teams for planning (per Part I, Section I), as well as utilization by the Council for Health Quality and Performance.	NL Health Services
Review and plan for collection of SDH data to be integrated into Family Care Teams where this data might reside outside of the health system (i.e., education, social services, justice, or housing).	HCS/NL Health Services
Integrate PCNL into the Family Care Team EMR including the establishment of PCNL, or similar technology, as a permanent function of Family Care Teams.	NL Health Services
Implement data sharing agreements plus technology for continuity of care from 811 and virtual care services.	NL Health Services
Provide appropriate change management to providers and citizens for successful digital rollouts within Family Care Teams.	NL Health Services

Implement the provincial virtual care program while ensuring continuity of care.	NL Health Services
Establish provincial virtual care policy and strategy.	HCS/NL Health Services
Develop a Provincial Digital Technology Strategy and Policy to guide e-technology development and implementation that aligns with the needs of Family Care Teams.	HCS/NL Health Services/OCIO
Ensure standards of practices(s) align for digital adoption.	HCS/NL Health Services/Professional Associations
Modernize Medical Care Plan (MCP) technology as required.	HCS/NL Health Services/OCIO
Develop digital identity technology required for citizens of Newfoundland and Labrador.	HCS/NL Health Services/OCIO
Develop digital technology integration plan when the new HIS is being planned. Synchronous and asynchronous integration is required between the EMR and HIS.	NL Health Services

I. Analytics and Performance Monitoring

Clinical analytics involves using data to produce information to guide decision-making in the planning, clinical service delivery, and management of health care. Routine health care interactions generate vast amounts of data that can be analyzed to reveal important clinical patterns and relationships. Data is most useful when a set of common guidelines and indicators are used. Development and implementation of consistent and standardized data metrics, collection, analysis, and reporting is an integral component of Family Care Team performance monitoring and accountability.

The knowledge gained from clinical analytics may be used to inform direct care, CQI, and population-based chronic disease prevention and management. According to the Canadian Foundation for Health Care Improvement, "analytics assist the process of turning raw data into information and insight that can be used for decision making and taking action."[17]

The Canadian Institute of Health Information (CIHI) Pan-Canadian PHC Indicators are widely used for performance monitoring. They are organized according to categories such as safety, access, and appropriateness. Each category contains specific metrics and instructions. For example, under the category of access, a specific metric is 'percentage of the population with a regular PHC provider.' PHC providers across the country are encouraged to use CIHI's Pan-Canadian PHC Indicators wherever possible to create a comparable approach to performance monitoring.

Newfoundland and Labrador Health Services recognizes the importance of monitoring the health and well-being of communities by completing regular cycles of CHAs. Newfoundland and Labrador Health Services completes CHAs every three years to align with the strategic planning cycle. The findings of a consistent CHA process provide an important source of data that allows comparisons over time and between regions. These findings are important in and of themselves, and in combination with practice-based knowledge to inform data-driven improvement in Family Care Teams. The Chief Medical Officer of Health, under the Public Health Protection and Promotion Act, must complete a PHA every five years, which is supported by Newfoundland and Labrador Health Services.

HCS has a primary role and responsibility in monitoring the overall performance and functioning of the health care system including the implementation and ongoing effective operations of Family Care Teams. HCS will identify regular reporting requirements, mechanisms, and intervals in conjunction with Newfoundland and Labrador Health Services.

Attribute Goal: Analytics, performance monitoring and evaluation is embedded into Family Care Teams.	
Attribute Objectives:	**Responsible Governing Bodies**
Develop a provincial framework for performance monitoring and evaluation of Family Care Teams.	HCS/NL Health Services
Determine methods to measure the impact of Family Care Teams across sub-groups of the population.	NL Health Services
Define/develop a set of metrics to assess Family Care Teams in the province, which would include metrics for SDH, on an individual and population health level.	HCS/NL Health Services
Include core and optional measures from CIHI's Pan-Canadian PHC indicators, as well as locally developed metrics that are relevant in this province (including relevant chronic disease indicators).	HCS/NL Health Services
Develop a PHC dashboard for reporting metrics publically.	HCS/NL Health Services
Identify protected time for the Family Care Teams to engage in analytics and performance monitoring activities.	NL Health Services
Ensure existing and emerging channels for supporting CQI priorities (per Part I, Section J).	NL Health Services
Include analytics and performance monitoring in data governance framework.	NL Health Services
Measure cultural safety within and across Family Care Teams (as determined by individuals receiving care).	NL Health Services

J. Continuous Quality Improvement

In health care, CQI is defined as the deliberate and defined processes and methods that are used to continuously develop, design, evaluate and change practices and programs to ensure that they are of high quality[18]. CQI is essential to effective PHC, given the complexity of elements that influence health outcomes. It is necessary to continuously evaluate and adjust services to support the needs of individuals, families, communities and overall demographics. Newfoundland and Labrador Family Care Team models will support CQI by combining the skills of trained practice improvement leaders with the knowledge, participation, and assets of communities. Family Care Teams intentionally practicing CQI are more likely to adopt evidence-based guidelines and to improve their capacity for change. An important opportunity for CQI in this province is enhanced integration of evidence-based practices for chronic disease prevention and management within clinical practice and community wellness initiatives. In addition, Newfoundland and Labrador has a rapidly aging population, therefore, using CQI processes to ensure Family Care Team services meet the needs of seniors and help them maintain health and independence in communities will be critical.

It is essential that Family Care Teams have access to change management resources (e.g., practice facilitation coaches) to develop the capacity to engage in improvement initiatives. Family Care Teams must be supported in the measurement and analysis of their own operations and, if needed, to adjust services to best meet the needs of people. The integration of CQI is closely linked to other attributes of Family Care Teams. As Family Care Teams become mature in their use of electronic record keeping and analytics, and establish strong partnerships within their community, the application of CQI becomes a shared responsibility. Given the ongoing and cyclical nature of CQI, it is essential that teams cultivate their own capacity and develop internal improvement expertise.

Family Practice Renewal Program's My Q Program

MyQ provides family physicians with support and programming to improve processes in their clinics. This will lead to better quality of care for patients and better patient and team experience. The program is unique and built-to-fit each family physician and their specific clinics.

EMRs can support analytics and CQI. By ensuring clinical information and practices are documented appropriately, teams can use their EMR to run reports, implement clinical decision support community heath triggers, and view dashboards depicting the status of chronic disease management. The same software can be used to evaluate change in a process or outcome. Rather than expect individual teams to create these software reminders, eDOCSNL, as a provincial PHC partner, can create and deploy EMR tools for widespread use. These pre-built resources will be valuable in helping teams monitor and analyze their work. Medication review is an example of a key area where this type of methodology could be deployed.

Learning Health and Social Systems (LHSS) are methods in which knowledge generation processes

are embedded into daily practice to produce continual improvement in care. CQI processes contribute greatly to a LHSS. To achieve this new and broader vision, HANL proposes incorporating a LHSS culture into all functions of the Family Care Teams.

Attribute Goal: Family Care Teams have a culture of quality and comprehensive, effective, and sustainable continuous quality improvement/Learning Health and Social System practices.	
Attribute Objectives:	**Responsible Governing Bodies**
Develop a Family Care Team CQI strategy and implement CQI initiatives.	NL Health Services
Identify Family Care Team LHSS/quality lead(s) that have the necessary CQI competencies and prioritize CQI.	NL Health Services
Ensure the LHSS/quality lead coordinates opportunities for the Family Care Team to meet at least monthly around CQI.	NL Health Services
Ensure Family Care Team quality leads meet at least quarterly with the local Family Care Team Leadership Committee to develop and monitor a Quality Management Plan and disseminate CQI reporting to FPNs on a regular basis.	NL Health Services
Disseminate, through the LHSS/quality lead, Choosing Wisely Canada, QCNL and other best practice resources.	NL Health Services/ QCNL
Integrate and evaluate evidence-based practices and tools for chronic disease prevention, screening and management, and use triggers and tools integrated within EMR where possible.	NL Health Services
Expand and strengthen evidence-based chronic disease prevention and management programs (i.e., BETTER/INSPIRE).	HCS/NL Health Services
Ensure cultural humility training and anti-racism policies are in place.	NL Health Services
Provide training opportunities for working with vulnerable populations that may be high risk or have complex needs based on gender diversity, age, mental health and addictions, immigrant/refugee or newcomer status, Indigeneity, living in poverty, etc.	NL Health Services/ MUNL

Provide training in Care of Older Adults, integrate Clinical Frailty Screening, ensure clinical service delivery is responsive to aging population needs, and develop pathways to specialized geriatric services and consultation.	MUNL/QCNL/FPRP
Ensure all Family Care Team providers are working to their full scope of practice.	HCS/NL Health Services/Professional associations
Leverage the CSC mechanism and FPRP resources in CQI initiatives including the Practice Improvement Program (e.g., MyQ).	NL Health Services/ FPRP

Part 2

Planning and Implementation Expectations

This section comprises the foundational and overarching planning expectations for the initial implementation and rollout of Family Care Teams. It is recognized that Family Care Teams will expand and integrate over time and that additional operational and clinical policies and procedures will need to be developed to support Family Care Teams within the proposed governance structures.

A. Planning, Resourcing and Financing Family Care Teams

1. Needs Based Resource Planning

Needs based planning for health human resources is a critical step for Family Care Team development. It is the ongoing process of assessing and documenting the strengths and resource needs of a community. In turn, these resources will be allocated based on the outlined needs and availability of health human resources. Several frameworks for health human resource planning exist and can be used when planning for Family Care Teams[20].

Goal: Family Care Teams are created based on the identified and unique needs of the population residing in the defined geographic area which they serve.	
Key Objectives:	**Responsible Governing Bodies**
Determine the geographic area and demographics of the population served by the Family Care Team.	NL Health Services
Utilize available data to identify community needs (i.e., demographic and socio-economic data, population health data, CHAs, PHAs, EMR data, existing program and service data, client feedback, and feedback from HCPs within Newfoundland and Labrador Health Services and community).	NL Health Services
Determine the professional positions available and required to meet specific local needs.	HCS/NL Health Services/ MUNL
Ensure Family Care Teams are inclusive and responsive to the needs of specific populations/issues, vulnerable and under-served groups such as frail elderly, children and youth at risk, MHA, Indigenous people and homelessness.	HCS/NL Health Services/ CSSD

2. Family Care Team Members

The base size, composition and skill mix of a Family Care Team should reflect the needs of the population and will ultimately depend on availability of HCPs within the geographical area. At a minimum, each Family Care Team should consist of an identified Family Care Team Manager, Clinical Director (physician), FPs, NPs, nurses, social worker, Social Navigator, Clinical Navigator, pharmacist, and administrative/clerical support. Enhanced services of allied health professionals (e.g., dietitians, occupational therapists, and physiotherapists) will be added where needed and feasible. Consideration will be given to adding HCPs that currently deliver community-based programs such as MHA, PH and CSS that can be integrated within the Family Care Team. Positions may be integrated from existing acute care, community health and/or community-based practices or governments/agencies. They will be supported through dedicated change management efforts. The goal is to establish high functioning, multi-disciplinary teams in an efficient and sustainable manner while maximizing available resources to deliver strategic, coordinated and organized care, regardless of geography location in the province.

The roles of Family Care Team Manager and Clinical Director (physician) are critical to the effective function and governance of each Family Care Team and must be identified/hired in early stages (refer to Part I, Section A). Family Care Team Managers should be selected based on core competencies and demonstrated ability to lead and champion change and create and sustain effective team functioning, relationships and integration. Identifying these positions may require net new resources or the realignment of existing Newfoundland and Labrador Health Services management positions. The Family Care Team Manager will play a pivotal role in the planning, function and operation of each Family Care Team including the reorganization of existing Newfoundland and Labrador Health Services community programs and working closely with applicable program managers. The Clinical Director (physician) is also critical to effective function and governance to engage all FPs in Family Care Teams and support the overall clinical service delivery model, including prioritizing medical education. Reporting relationships for these roles will be informed by the organizational structure of Newfoundland and Labrador Health Services.

New position descriptions will be created and others updated for all Family Care Team roles and will be part of the orientation provided to team members. It is important for each HCP to understand their own responsibilities and duties and how their roles relate to one another. Similarly, the role of providers in a community-based practice will be outlined through affiliation agreements. The CFPC's Best Advice – Team-Based Care in the Patient's Medical Home, created with the assistance of national professional organizations, outlines health professional role descriptions for collaborative, multidisciplinary PHC teams, and can also serve as a guide[21].

3. Models of Service Delivery

A population base of 7,000-8,000 and upwards is a guide for Family Care Teams, with special considerations/arrangements (including linkages to larger teams) for smaller or more remote communities[22]. Table 1 provides a recommended guide for population panels.

Table 1: Guide to Patient Panel based on population size[23]

Number of Patients	HCP
1,250-1,500	1.0 FTE FP
800	1.0 FTE NP
300-500	1.0 FTE RN

*CFPC – Best Advice Panel Size (2012). This panel may vary based on a number of criteria and as resources are updated.

Local circumstances must be taken into account when establishing panel targets, recognizing that many providers may have continued or additional responsibilities outside of Family Care Team work (e.g., emergency department coverage, hospital work, long-term care, academic responsibilities, etc.). Some providers may directly support the stability of other components of local, integrated health services – particularly in areas with Category B facilities. At the same time, strong accessible PHC through Family Care Teams will reduce other pressures on the other parts of the health care continuum.

Family Care Teams may operate using a "hub and spoke" model. Hub and spoke models are focused on delivering appropriate and equitable care to an entire geographical area and are particularly important to servicing smaller and remote areas by providing consultation, support and specialized services (e.g., addictions medicine) to a spoke site. Resources are typically concentrated in a hub location supporting one or more spoke sites. Hubs will provide consultation and support to the PCPs and patients in the spokes. Hub PCPs may travel to and/or provide virtual care to spoke sites. People living near a spoke site will also have the option to directly access services at a hub site if they choose. Where additional capacity may exist in a spoke site, the reverse may also be possible. Spokes are usually located in outlying areas to increase access to PHC in both urban and rural areas. Hub and spoke models may also consist of networks of several teams existing across regions that may support each other.

In Newfoundland and Labrador, we are working to increase the role and numbers of NPs in PHC. NPs provide a wide range of direct care services to people at every stage of life. In addition to treating illnesses, they teach individuals and their families about healthy living, preventing disease, and managing illness. NPs work with, rather than replace, other HCPs. They are part of a collaborative team that includes RNs, FPs, social workers and others[24]. Within the Family Care Team, a NP or FP can attach patients and NPs will be the MRP for their own patients. NP led clinics will be a key feature of the Family Care Team model, particularly within the hub and spoke model. NPs will be paid as salaried members of the team. The governance of NP led clinics in Newfoundland and Labrador will be provided by the governance structure[25] for the geographical Family Care Team. This is distinct from Ontario, where there is a separate governance structure. NP led clinics and Regional Nursing Models are great examples of how the jurisdictions are reshaping traditional models of care and increasing access, especially in rural and remote communities. It is essential to build on those models of care and their capacity to respond to the needs of our geographically dispersed population.

In some remote areas of the province (e.g., coastal Labrador), a Regional Nursing Model has been implemented. This model provides preventative, supportive, rehabilitative, curative, and palliative interventions to the people of the community. Regional nurses offer an opportunity to apply advanced nursing knowledge and decision-making skills while managing a generalized PHC program by working collaboratively within an interdisciplinary team. The regional nurse works in a geographically isolated clinic, assuming a high level of autonomy and responsibility, and exercises considerable judgment and initiative in performing client care. The regional nurse follows Clinical Practice Guidelines for Nurses in Primary Care[26] for communicating diagnoses, ordering diagnostic tests, dispensing medications, and consulting with other HCPs.

The "Stepped Care" model of care adopted by provincial MHA services provides a useful framework for the integration of MHA care into Family Care Teams. Stepped care is an evidence-based system of intervention stages. It uses outcome monitoring to ensure that clients first receive the most effective and least intensive treatment. Based on an initial assessment, the client and clinician agree on the lowest intensity intervention warranted. Care is stepped up or down depending on what the client needs or prefers based on the continual monitoring of outcomes. To begin stepped care, the client works collaboratively with an experienced provider to assess and determine the best available combination of resources or programs related to their level of need and presenting issues[27]. Trauma-informed, harm reduction approaches should be used as appropriate.

Goal: Family Care Teams use innovative and appropriate models of service delivery.	
Key Objectives:	**Responsible Governing Bodies**
Incorporate appropriate models of service delivery into Family Care Teams.	NL Health Services
Work with MUNL to ensure Family Care Teams include medical learners in all models of service delivery.	NL Health Services/MUNL
Create new role and position descriptions for all team members.	HCS/NL Health Services
Conduct a review and realign models and levels of nursing care within and available to Family Care Teams (e.g., primary care nursing, community health nursing, regional nursing model, NP led clinics, etc.)	HCS/NL Health Services

Newfoundland and Labrador Opioid Dependence Treatment (ODT) Hubs provide "rapid access" to medication-assisted treatments, coordinate referrals for ongoing care and provide consultation and support. This Hub and Spoke model delivers evidence-informed, comprehensive and coordinated ODT services. There is opportunity to integrate addictions medicine and capacity building within Family Care Teams.

4. Operational Expectations for Access to Family Care Teams

As stated in the introduction of this framework, the vision for Newfoundland and Labrador Family Care Teams relates to providing timely access within an interconnected network. Therefore, Family Care Teams need to ensure their daily operations go beyond co-location of providers. Effective and efficient PHC delivery through Family Care Teams requires collaboration and communication between and across providers, including community-based practices. In order to maximize a person-centred health care model, providers must embrace the integrated team-based approach.

Within the Family Care Team, new and innovative approaches to care and service are required to support enhanced access and continuity of care for clients within the community setting. High functioning Family Care Teams, with a strong focus on chronic disease screening, SDH, prevention and management, should help reduce unnecessary emergency department visits and help prevent admissions to, and reduce lengths of stay in, acute care.

Enhanced technological capabilities for viewing client health information is imperative for this delivery model. Electronic record keeping supports informational continuity by allowing real-time access to critical information, and appropriate sharing of information both within teams and across an integrated continuum of care. Family Care Teams will use scheduling models for providers to enable improved access to care that better meets the needs of clients and the community.

In order to rebalance the health system from an overreliance on acute care to community care, as per the HANL vision, and to ensure optimal, appropriate and accessible care is provided within Family Care Teams, enhanced access beyond traditional community clinic hours (i.e., 8:30am-4:30pm Monday-Friday) will be required. For the intended impact on patient access and utilization indicators, Family Care Teams must be resourced to enable a combination of scheduled and same day appointments, based on need, and have extended hours of operation and weekend availability, as well as arrangements in place for coverage when a patient's MRP is unavailable.

Particulars of daily workflows and clinical pathways of Family Care Team operations will be determined through the development of standard operating procedures.

Goal: Family Care Teams provide enhanced access to community-based PHC.	
Key Expectations:	**Responsible Governing Bodies**
Establish a base daily appointment target for each Family Care Team.	NL Health Services
Establish a minimum acceptable time-to-access services and monitor when access time is outside target.	NL Health Services
Monitor daily, weekly, and monthly encounter volumes.	NL Health Services
Provide enhanced access (i.e., beyond Monday to Friday) with scheduled, same-day, evening and weekend availability.	NL Health Services
Provide a combination of office based, in-home, mobile and virtual access	NL Health Services
Establish linkages between Family Care Teams and the 23 health centres and ensure pathways to urgent care services as required.	NL Health Services
Ensure Family Care Teams have processes in place to provide access to an alternative PCP when a client's MRP is not available.	NL Health Services
Ensure health human resources are managed to ensure continuous coverage is provided and core service delivery is maintained, through peak vacation periods and other events.	NL Health Services
Ensure people have direct access to all Family Care Team providers without the need for referral.	NL Health Services
Develop standards for Family Care Teams onsite clinical supplies, pharmaceuticals and equipment as well as clinic procedures that can be performed within a typical Family Care Team setting.	NL Health Services
Implement online appointment booking and email or text appointment notifications.	NL Health Services

5. Criteria for Funding

HCS will use a phased approach for funding Family Care Teams. Newfoundland and Labrador Health Services will be expected to submit funding proposals for Family Care Teams to HCS in accordance with other departmental budget process guidelines in effect for the fiscal year and below criteria. Typically, budget deadlines for the following fiscal year occur within the third quarter. Funding timelines and decisions will be outlined and circulated to appropriate partners as they are finalized.

1. **Demonstrate needs assessment of catchment area (per Part II, Section A (1)):**
    - Use CHA and other needs assessment data to assess needs of area.
    - Indicate population and demographics.
    - Incorporate current needs assessment and other analytic data outlined for proposed catchment area.
    - Engage the community and providers in the planning of the Family Care Team (e.g., CACs, CSCs with FPNs, IGOs, municipalities, etc.).
2. **Models of care**
    - Outline all models of care planned to be utilized for the Family Care Team (i.e., hub and spoke, virtual care, stepped care, integration of Newfoundland and Labrador Health Services and community programs).
3. **Inventory of existing resources**
    - Demonstrate a review of existing resources in the area including all Newfoundland and Labrador Health Services community health programs.
    - Include an inventory of existing and available Newfoundland and Labrador Health Services resources for the Family Care Team, including any resources available from restructuring of health centres and realignments.
4. **Required positions to augment existing resources**
    - Include all required new resources required to supplement and support models of care along with existing resources.
    - Identify the Family Care Team Manager and core providers for Family Care Teams indicating existing and new resources required.
    - Consider other responsibilities of PCPs in the allocation of resources needed (e.g., FP hospital roles).
    - Consider new operational hours for the Family Care Team when developing roles and job descriptions for new and existing resources.
    - New salaried physician requests should detail the existing complement in a geographical area, supporting data and show evidence that reallocations/changes within the existing local and/or regional complement have been considered and will be subject to the Salaried Physicians Approval Committee review and recommendations.
5. **Infrastructure considerations**
    - Include all infrastructure needs for short and long term (e.g., existing or new space requirements, equipment, technology, co-location considerations, vehicles, etc.).
    - Infrastructure considerations for health education (e.g., study space, technology, clinical observation, conference and meeting rooms).
6. **Proposed partnerships**
    - Identify all community-based practices and partnerships integral in the development of the Family Care Team (e.g., community pharmacies, allied health, family practices, and IGOs).
    - Identify all required affiliation agreements (standards to be developed).
    - Partner with academic institutions to make Family Care Teams learning teams.

7. **A detailed budget (including all existing and new resources required)**
    - Outline detailed budget for the proposed Family Care Team including existing and new resources.
8. **A detailed timeline**
    - Include timelines for all implementation plans.

6. Recruitment and Retention

Recruitment and retention of HCPs is a major challenge throughout the province, particularly in rural and remote regions. The Provincial Health Professional Recruitment and Retention Office (PHPRRO) is designed to support leadership, innovation and resources required to attract and retain more qualified physicians, nurses, paramedics, pharmacists, and allied health professionals to Family Care Teams. The PHPRRO will align recruitment and retention with the evolving needs of current workforce.

Goal: Family Care Team needs are included in the development of a provincial health workforce planning strategy.	
Key Objectives:	**Responsible Governing Bodies**
Ensure collaboration amongst PHPRRO and Newfoundland and Labrador Health Services recruitment teams, and other key stakeholders (e.g., academic institutions and professional bodies).	HCS/NL Health Services/ CSC/FPN/MUNL
Align recruitment and retention initiatives to the evolving needs and preferences of current workforce and new graduates.	HCS/NL Health Services/ FPRP/FPN/CSC
Measure provider satisfaction and well-being.	NL Health Services
Promote the benefits of working on Family Care Teams within recruitment strategies.	HCS/NL Health Services/ FPRP/FPN/CSC
Ensure the provincial health workforce planning strategy includes approach for recruitment and retention of Family Care Team HCPs.	HCS
Ensure Newfoundland and Labrador Health Services and FPNs avail of the CSCs on recruitment and sustainability of FP resources.	HCS/FPRP
Develop effective remuneration options and incentives for HCPs within collective agreements and initiatives as per appropriate processes.	HCS/Professional Associations/Unions
Engage community-based partners in recruitment and sustainability strategies for local Family Care Team providers (e.g., municipalities).	NL Health Services

7. Professional Education and Training

Newfoundland and Labrador's Family Care Team model will incorporate professional education, teaching and learning for new HCPs. This ensures future health professional graduates have the necessary skills and competencies required to work inter-professionally. It also improves opportunities for recruitment and retention, adding stability and sustainability to our health care system.

HCPs require specific knowledge and skills to work effectively in inter-professional teams. Offering professional training and education is an effective means to equip health workers for a collaborative work environment. A collaborative practice-ready HCP is someone who has the competencies to work in an inter-professional environment where there is collective recognition of patient goals and joint intervention between HCPs, the patient, and their family.

Potential education and training opportunities within Family Care Teams include expansion of Family Medicine teaching clinics, expansion of nursing clinical training, expansion of allied health clinical training, and multi-layered learning opportunities across disciplines.

Goal: All Family Care Teams are sites for professional learning and education.	
Key Objectives:	**Responsible Governing Bodies**
Promote and integrate with the existing Physician Leadership and Management Program, Faculty of Medicine at MUNL.	HCS/MUNL/NL Health Services/OPED
Establish Family Care Teams as clinical training sites for health care professionals.	HCS/NL Health Services/ MUNL
Hire consultant to examine potential for expansion of MUN Faculty of Medicine, Discipline of Family Medicine program into Family Care Teams	MUNL/HCS

8. Linkages to Other Practices

Recognizing the excellent work and deep longitudinal relationships in primary care between FPs, NPs and their clients, the development of Family Care Teams throughout the province needs to build on the existing structure of community-based practices and develop appropriate linkages, affiliations and remuneration models that support and promote team-based care.

Nearly two-thirds of FPs and an estimated 325,000 patients are exclusively in the community-based family practice sector. As such, mechanisms to collaborate with community-based providers (e.g., affiliation agreements) will be created to promote team-based care for existing community-based practices and integrate them into the team structure, while respecting the vital role these practices play in the PHC system. The integration of community-based practices will support the stability and integrity of the primary care practices. Roles and responsibilities of all team members, including community partners, will be clearly defined at an operational level. Expectations, including accountability and reporting structure, will be defined through the governance structure.

Clients without health insurance and/or the financial means to pay face barriers to the services of allied health professionals in community-based practice. Unlike FPs in this province, allied health providers, nurses, and pharmacists in community-based practice cannot bill MCP. Health providers in community-based practice need to be engaged through affiliation agreements and/or service contracts with Family Care Teams (e.g., a community pharmacist or privately operating physiotherapist or chiropractor).

Goal: Mechanisms are in place to connect community-based practices (e.g. Family Practices, Allied Health, and Pharmacies) and Indigenous health services with Family Care Teams.	
Key Results:	**Responsible Governing Bodies**
Complete affiliation agreements between community-based practices.	NL Health Services
Connect Family Care Teams with Indigenous health services where there is mutual agreement.	NL Health Services/IGOs
Create payment structures that incentivize and promote team-based care for existing community-based-practices.	HCS/NL Health Services/ Professional Associations/ Unions
Develop new financial programs, within the province's fiscal envelope, to ensure access to community-based services typically available only to those who have insurance or can afford to pay (e.g., massage therapy, physiotherapy).	HCS

9. Integration of Existing Newfoundland and Labrador Health Services Programs and Services

This section highlights existing Newfoundland and Labrador Health Services community health programs and services, and their important roles and potential within Family Care Teams. As appropriate, Family Care Teams will be comprised of existing Newfoundland and Labrador Health Services community health programs and personnel. Opportunity exists for Newfoundland and Labrador's 35 Family Care Teams to become an innovative service delivery framework for the integration of existing Newfoundland and Labrador Health Services community health programs. Integration can effectively and efficiently support the holistic and varied physical and mental health care needs of individuals, families and communities across the lifespan and improve overall access to a full suite of high quality community-based services and expertise. Such integration has opportunity to enhance the full team potential, capacity and satisfaction beyond a basic Family Care Team. This integration can be best achieved through a shared vision, strong team leadership, sustained change management efforts, facilitated IPC, and co-location where possible. Significant engagement is required to optimize the best approach and should be identified in the Family Care Team operational plan (for additional information see Appendix E).

B. Change Management and Communications

Change management is a collective term for all approaches to prepare, support and help individuals, teams and organizations in making organizational change. Meaningful change management results in a change of attitudes, approaches, buy-in, beliefs and, ultimately, culture. Change management is difficult and requires dedicated effort and resources over a sustained timeframe. Change management is a systematic and methodical process that considers why and how changes will affect all stakeholders.

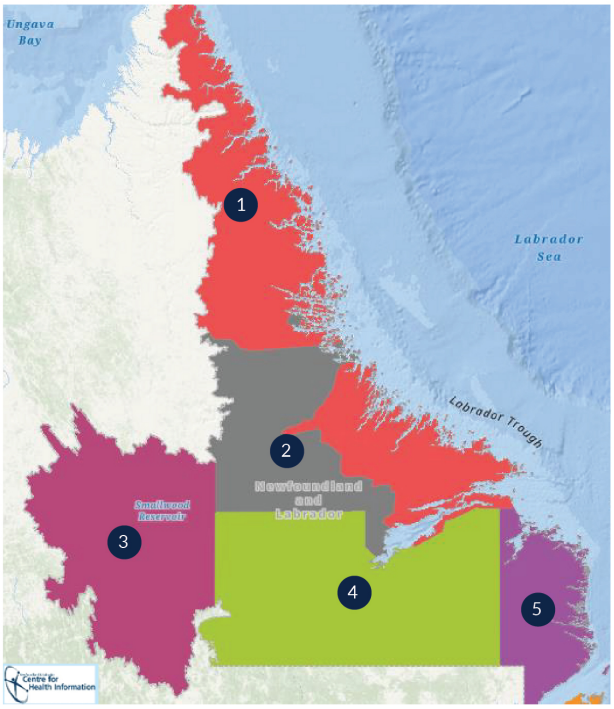
Poor health outcomes and high health spending were the impetus for the work of HANL. Health professionals from diverse backgrounds used evidence, strategies, and engagement to develop the 10-year blueprint for health reform. Implementation of practice transformation is undoubtedly a challenging endeavour that requires a specialized skill set. The challenges are numerous, including unique systemic, monetary, and cultural barriers. Recognizing these challenges, change management practice takes into consideration potential barriers to success.

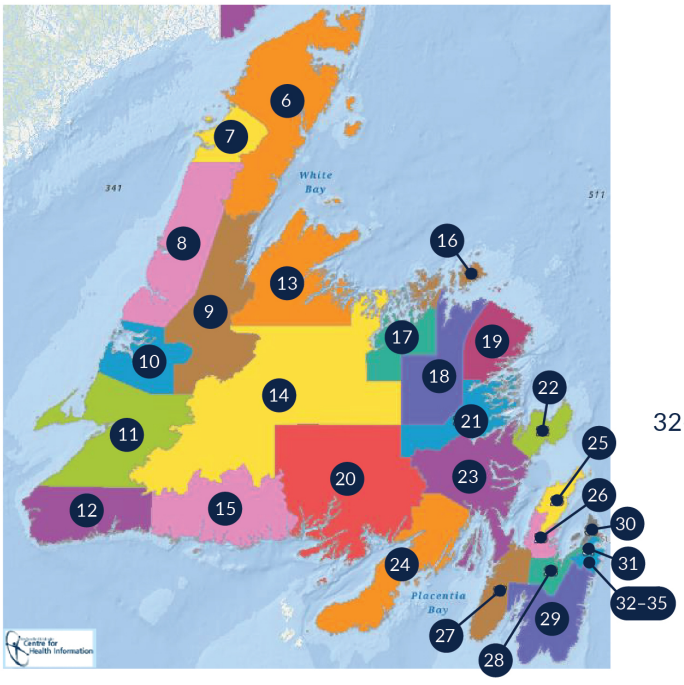
Change management support is fundamental to the scaling of Family Care Teams and the long-term cultural shift required within the health system. A well-resourced change management team with participation of the provincial government, policy makers, health and social systems, individual providers, and the public should lead this strategy. A plethora of change management strategies and frameworks exist. Consideration will be given to which approach is best suited to deliver Family Care Team implementation with maximum impact in Newfoundland and Labrador.

Goal: Change management strategies and communications plans are in place to support Family Care Teams.	
Key Objectives:	**Responsible Governing Bodies**
Establish a provincial change management strategy/plan, for Family Care Teams.	HCS/NL Health Services
Support Family Care Team leaders through a provincial change management team, strategy, and structure.	HCS/NL Health Services
Support Family Care Team leaders to avail of new and existing change management resources (e.g., FPRP practice facilitation role; clinical adoption specialists; and practice improvement leaders/coaches to support IPC).	HCS/NL Health Services/ FPRP
Ensure the position descriptions for Family Care Team leaders include change management as a key priority, accountability and competency.	NL Health Services
Employ dedicated change management strategies to integrate existing Newfoundland and Labrador Health Services resources, and Indigenous health services, as appropriate, into Family Care Teams.	NL Health Services
Ensure change management resources are available to support digital health adoption.	NL Health Services
Include change management education and resources within a LHSS and web-based learning platform for teams.	HCS/NL Health Services/ MUNL/QCNL
Develop a provincial communication strategy/marketing plan for both the public and health care professionals regarding the introduction of Family Care Teams.	HCS/NL Health Services

Appendix A

HANL Proposed Areas for Family Care Teams





1 Northern Labrador
2 Innu Communities
3 Labrador West
4 Happy Valley-Goose Bay
5 South/Southeast Labrador
6 Northern Peninsula
7 Port Saunders area
8 Bonne Bay
9 Deer Lake/White Bay
10 Corner Brook – Bay of Islands
11 Bay St. George
12 Port aux Basques
13 Baie Verte/Springdale area
14 Grand Falls area
15 Burgeo
16 Fogo/Twillingate area
17 Lewisporte area
18 Gander/Gander Bay area
19 Brookfield to Centreville area
20 Harbour Breton area
21 Gambo to St. Brendan's
22 Bonavista
23 Clarenville and area
24 Burin Peninsula
25 Carbonear/Old Perlican area
26 Bay de Verde Peninsula South
27 Placentia/Whitbourne area
28 Paradise/CBS and area
29 Southern Shore
30 Portugal Cove/Torbay area
31 Mount Pearl
32–35 St. John's Metro

Fig 17. Proposed areas for Community Teams for Newfoundland and Labrador

Appendix B

Roles and Responsibilities

Department of Health and Community Services:

- Establish overarching provincial policy direction for Family Care Teams.
- Make funding decisions for Family Care Teams and allocated budget.
- Seek approvals as necessary (e.g., funding, legislative changes).
- Monitor and provide provincial oversight of Family Care Team implementation, performance and effectiveness in conjunction with Newfoundland and Labrador Health Services.
- Communicate to public and key stakeholders.
- Implement other related provincial action plans and strategies (e.g., virtual care strategy).

Newfoundland and Labrador Health Services:

- Include Family Care Teams implementation plan in Strategic Plan.
- Implement Family Care Teams into Newfoundland and Labrador Health Services organizational and governance structures.
- Submit applications to HCS for new and augmented Family Care Teams.
- Develop operational and clinical policy for Family Care Teams.
- Deliver clinical services and develop standards of care.
- Deliver client navigation and respond to client enquiries and complaints.
- Report Family Care Team statistics to HCS as required.
- Develop a communication plan with public and key stakeholders in each geographical area.
- Collect data for analytics, evaluation, and reporting purposes as appropriate.
- Produce a provincial PHC Dashboard.
- Support and analyze community needs assessment.
- Deliver digital health.
- Maintain electronic record keeping and support integration and panel management.
- Oversee PCNL.
- Provide clinical adoption and change management resources.

Indigenous Governments and Organizations:

- Advise on matters relevant to their communities.
- If agreeable, participate in the Family Care Team governance structure.
- If agreeable, integrate health services with the Family Care Team.
- Support Family Care Teams to provide culturally safe care.

Family Practice Renewal Program:

Transform family practice through:

- FPNs (each FPN is an incorporated organization with its own corporate board structure).
- Practice Improvement Program (e.g., MyQ, Practice Advisors).
- Fee Codes Program.
- Engage in the development and governance of the Family Care Team committee structures via CSCs.

Professional Colleges:

- Regulate HCPs, develop professional standards of practice, and ensure quality of care.
- Ensure effective and efficient licensing and registration processes.
- Investigate public practice complaints, and implement dispute resolution and disciplinary actions.
- Engage in scope of practice matters to support Family Care Teams.

Memorial University – Health Faculties, OPED and QCNL:

- Educate learners at the undergraduate, postgraduate and graduate levels.
- Provide clinical placements for learners for health professionals as well as interprofessional clinical placements.
- Improve the quality of care in Newfoundland and Labrador by facilitating change to ensure the right treatment gets to the right patient at the right time.
- Enable the promotion of established national guidelines and recommendations that cross all disciplines to support the reduction of low-value health care, including unnecessary tests and treatments.
- Lead inter-professional education and development.
- Develop and manage a resource hub to support IPC in Family Care Teams.
- Lead research, knowledge translation and exchange initiatives.
- Adapt training programs to meet future needs of the health care system, including Family Care Teams.

Other Government Departments:

- Responsible for policy, programs and legislation that may intersect with Family Care Teams, particularly around the SDH.
- Ensure integration of a “Health in All Policies” approach.

Appendix C

Establishing Continuity of Care

Continuity will be established through operationalization of the following concepts and activities:

Definitions for Continuity	
Attachment	Attachment is the documented confirmation of a continuous relationship between an individual and a PCP (traditionally, PHC relationships between people and PCPs have been based on an understanding, or a conversation, rather than purposefully documented).
Panel	A Panel refers to the group of individuals attached to a single provider. A panel is an inventory of documented attachment (i.e., panel for the individual PCP).
Roster	A Roster refers to a set of individuals attached to all collaborating providers within a Family Care Team or a community medical practice. A roster is an inventory of documented attachment (i.e., roster for the provider group).
Panel management	Panel management describes the activities required to maintain accurate attachment information for every individual within a panel or roster. Panel management is greatly enabled by electronic record keeping, especially the shared use of EMRs.

- Attachment and empanelment formalize relationships, providing benefits to individuals, PCPs and the health system.
    - Documented attachment makes it easier to understand the needs of a population. Knowledge of local demographics, burden of illness, and lifestyle factors within a caseload supports the design of effective services and models of access.
    - Operationalization of these concepts also relate to supporting remuneration models and statistical reporting at the system level for performance and evaluation purposes.
- Accurate Family Care Team rosters allow for real-time summaries of the number of individuals connected to a Family Care Team, the number of individuals within the Family Care Team that are attached to a PCP, and the number of individuals who are unattached to a PCP, enabling quality health management.
- Family Care Team rostering should be enabled by the provincial EMR system and support health management in LHSS and CQI activities:
    - EMR software is equipped with convenient mechanisms for verifying attachment using one-click actions whenever an individual's electronic chart is accessed.
    - This includes verification of each person's primary health identifier (MCP) and demographics, and reconciliation of information to ensure a person's status (i.e., active, inactive, deceased).
    - Panel management must be consistently undertaken using agreed-upon provincial standards and principles.
- Public awareness on the definition, benefits and mechanisms of attachment, along with respective roles and responsibilities in maintaining attachment, will be supported.

Appendix D

Digital Technology Requirements

Family Care Teams require technology, data, and digital connections to various health care and social services provided outside of the structures of a Family Care Team as well as educational institutions, as appropriate.

1. Technology and data within Family Care Teams is required for the day-to-day administration (i.e., scheduling of providers, patients, and clinic rooms). Day-to-day administration requires reporting of clinic information such as: total panel management (i.e., rostered patients), screening information, and patient follow up. An accurate, up-to-date, and complete patient chart is required for each rostered patient to enable individualized patient care management. Existing solutions can be implemented with some additional technology to meet this requirement.
    a. The majority of the requirements will be met with existing EMR solutions supported by the eDOCSNL program.
    b. The present EMR solution in Newfoundland and Labrador offers clinical best practice in certain areas; however, additional work is required.
    c. The integration of evidence-based guidelines into practice will be supported by implementation of the Council for Health Quality and Performance (e.g., diabetes management).
    d. Details of affiliation agreements will determine other requirements needing to be addressed. Synchronous and asynchronous communication will be required between the provider's clinic and Family Care Teams.
2. Family Care Teams require digital connectivity to health and social services outside of the Family Care Team along with patient data from community-based practices. Electronic ordering, prescribing, referrals to specialists, electronic consults for advice, and communication with private mental and allied health services require synchronous and asynchronous electronic communication for sending and receiving. This ensures Family Care Teams have the most up to date health and social information.
    a. HEALTHe NL is a digital health solution that Family Care Teams will leverage for patient information. Currently, HEALTHe NL offers laboratory results, diagnostic imaging results, community medication profiles, along with some immunization data.
    b. Electronic consult functionality in HEALTHe NL will be leveraged.
    c. Enhanced EMR functionality is required for communication across Family Care Teams plus Family Care Teams to community-based practices.
    d. Electronic prescribing from Family Care Teams to retail pharmacies is anticipated to be in place in late 2023.

e. Electronic ordering from Family Care Teams to cardiac and vascular services are in place today to be leveraged.
f. Electronic referral is not currently in place and will be required. An electronic referral database also does not exist.
g. Electronic communication to private allied health is not in place and will be required.
h. Integration of data including community-based mental health services and CRMS.
i. Data governance and associated policies are required to enable completion of this requirement.
j. Pathways for integration of IGO data need to be considered.

3. Patients require synchronous and asynchronous communication with the Family Care Team clinic.
    a. Residents of Newfoundland and Labrador will gain digital access to their basic health chart starting in 2023. This digital access will grant citizens access to laboratory and diagnostic imaging results.
    b. Technology will be added to the Family Care Team EMR, which enables other required patient synchronous and asynchronous communication. This technology will enable:
        i. Online appointment booking
        ii. Secure communication between patients and Family Care Team staff
        iii. Video appointments with Family Care Team providers
        iv. Patient access to their chart within the Family Care Team
    c. HCS and Newfoundland and Labrador Health Services working together on virtual care policies (remuneration structures are required).
    d. The public requires digital health education. A digital literacy awareness campaign is needed to complement the Family Care Team communication plan to the public.
    e. Equity will need to be considered for those not interested or unable to communicate digitally with Family Care Teams. This means being able to offer in person, phone and paper processes.
4. Aggregate Family Care Team data needs to be disseminated to Family Care Team leadership in Newfoundland and Labrador Health Services, HCS and the Council for Health Quality and Performance.
    a. The statutory review of PHIA will be a key to this requirement.
    b. CQI initiatives and clinical audits need to be considered. These should include all appropriate providers, including medical learners.
    c. Data governance, associated data policies, along with details of provider affiliation agreements are required.

Appendix E

Integration of Existing Newfoundland and Labrador Health Services Community Health Programs and Services into Family Care Team Model

Newfoundland and Labrador Health Services Community Health Programs and Family Care Teams

As noted in Part I, Section A and Part II, Section A (9), geographical Family Care Teams will be comprised in part by reorganizing existing Newfoundland and Labrador Health Services community health programs and personnel as appropriate under the framework of a Family Care Team. Consider again the definition of PHC, as introduced in Part I, as "the essential care that is based in our communities and is often our first point of contact with the health care system, it includes the services and supports that allow us to maintain and improve our physical and mental well-being". Community health services in Newfoundland and Labrador Health Services have traditionally operated from a "program-based" versus a "collaborative team" model. Community health programs, aside from primary care/family medicine services, operate predominantly from three distinct program areas: PH, MHA and CSS.

Breaking down existing silos enables value added health care, as the potential of the "whole team" is greater than the sum of its parts. While some of these programs may already be co-located and have interconnections, they are not currently operating from a formal team-based approach to PHC service delivery. The Family Care Team model (while maintaining program integrity, specific mandates and directions, clinical supervision arrangements and adhering to any relevant legislation), provides a framework for these programs to integrate through effective team-based leadership to service the holistic health needs of the geographical area (i.e., 35 geographical teams). This integration requires more than co-location, and while co-location is ideal, it is not essential. What is required is an "intentional and orchestrated approach" to build the team vision, identity, cohesion and optimal team collaboration and functioning. This requires support from senior HCS and Newfoundland and Labrador Health Services executive leadership, dedicated leadership, facilitation and change management at the frontline level, as well as technological enablers for sharing of information and professional competency development in IPC.

The Patient/Person at the Centre of Care

Newfoundland and Labrador's transition to Family Care Teams focuses on fostering a shared-vision of prioritizing person-centred care. The Newfoundland and Labrador Family Care Team model places the needs of the patient and the community at the centre and this requires strong cohesion between existing programs. Placing peoples' holistic needs (i.e., physical, mental and social needs), versus program siloes, at the forefront guides providers as they function both independently and as part of the team. With a mutual understanding of meeting the patient's needs first, each provider within a team may function within their own regulated professional scope of practice, while also ensuring individuals access the right care at the right time, from the most appropriate provider(s) on the team. Communication and referral processes within the team require simplification and efficiency (e.g. application of LEAN methods) to facilitate appropriate, accessible and effective care and to remove any unnecessary delays or barriers to care. It will be critical to have patient/person-centred care represented at the local Family Care Team Leadership Committee to ensure co-design of local solutions to care delivery. This

Part of the Policy Framework will examine how each of the existing community programs and services can integrate under the umbrella of a geographical based Family Care Team. Each section will provide: a preamble, objectives to support the Family Care Team vision, and specific programs, resources and/or training available to support team based care. The provincial Family Care Team Steering and Operational Committees will develop specific strategies around integration, including consideration of the following:

- Service delivery in current community-based programming is largely defined by program boundaries, eligibility criteria, allocation of program budgets and human resources, with distinct governance structures. Some shifting may be required to re-align with geographical teams.
- Clinicians providing these services are supported by various collective agreements, which must be considered in the reorganization of service delivery.
- Change management and meaningful engagement in the design is necessary to successful development of a more person-centred and less program centric model.
- Roles and responsibilities, including provision of clinical assessment and case management, will need to be further examined and delineated as services begin to integrate. The roles of the MRP and case management are not mutually exclusive, but will require clarity and role delineation.

Integration of Public Health

Preamble

PH in Newfoundland and Labrador refers to combined programs, services and policies that protect the safety and improve the health of the population by keeping people healthy and by preventing illness, disability, injury and premature death. Core function areas, some of which are outlined in legislation, include PHAs, public health surveillance, health promotion, disease and injury prevention, health protection and emergency management.[28] PH uses a SDH approach at both individual and population level interventions to improve health outcomes and reduce health inequities. The value added by integrating PH into Family Care Teams is the view of health and well-being from the population, or community level – this will help improve the overall health of the community serviced by the Family Care Team.

Integrating Specific Program Components

a. Orient all Family Care Team members to the diversity of roles and availability of/access to relevant PH workforce for their community (e.g., Medical Officers of Health, PH nursing, health promotion consultants, community developers, environmental health inspectors, cultural knowledge keepers, and epidemiologists).
b. Determine the right person-right time approach in roles where current overlap or gaps might be identified (e.g., immunization programs, well baby checks), providing an integrated approach.
c. Ensure all community needs assessments include PH components (e.g., tobacco control, water quality, sanitization, food safety, motor vehicle safety and helmet use, use of car seats, air pollution, etc.), and other relevant environmental and SDH factors that impact the health and well-being of the community.

d. Ensure PH staff have access and means to share relevant data to inform and receive information to ensure maximum contribution to Family Care Teams (e.g., child health programs and children in care service providers).
e. Support mechanisms for surveillance for PH (e.g., communicable diseases, substance use) with feedback at the local Family Care Team level to enhance collective responses and impact.
f. Support harm reduction approaches and removal of barriers to treatment for substance use disorders.
g. Collect, regularly update and promote local availability of community-based services (e.g., breast feeding support, foodbanks) by Social Navigators and Clinical Navigators within Family Care Teams, community family medicine clinics, and 811 HealthLine.
h. Optimize community level partnerships with wellness coalitions, CACs, family resource centres, municipal partners, and patient/client-led self-help groups. Family Care Team members should have knowledge of and connection to these groups and their programs and services, in order to inform and link patients/clients.
i. Ensure funding models for Family Care Teams, based upon community needs data, incorporates support for the PH workforce and other resources.
j. Include PH in the overall governance model for Family Care Teams by including the Chief Medical Officer of Health on the provincial Family Care Team Steering Committee.
k. Position PH as a liaison for Family Care Teams on community-based emergency preparedness planning and response.
l. Position PH as lead roles within Family Care Teams on health promotion and collaboration with community stakeholders as needed to take action on SDH.

Role of Public Health Nurse in Family Care Teams

Family Care Teams will include a variety of registered nursing staff. The specific role of a Public Health Nurse will be maintained to include provision of pre- and post-natal education, care and support, Healthy Beginnings program, breastfeeding support, child health clinics, preschool health check clinics, immunizations, school health, sexual health and lifestyles coaching and support.

Public Health Nurses will be included in regular Family Care Team meetings and, as necessary, team conferences to plan care for patients and/or families and address population health needs.
Public Health Resources for Family Care Teams

- Review and integrate relevant information stemming from the **Public Health Protection and Promotion Act** (e.g., five-year review plan) and data from the PHA into team planning.
- Develop mechanisms (i.e., standardized tools and collection methods) for all Family Care Team members to participate, as appropriate to role, situation and legislative requirements, in the monitoring and surveillance of public health issues (e.g., reporting of communicable diseases, increase in substances of concern, etc.).
- Support the dissemination of intersectoral research and guidelines from experts such as national collaborating centres for PH, as they serve as knowledge hubs for Family Care Teams (e.g., communicable disease control, healthy living, emergency preparedness, and national alcohol guidelines).

Newfoundland and Labrador Health Services MHA services aim to promote mental well-being and build resilience for individuals, families and communities through awareness, prevention, early intervention, treatment, and recovery supports for mental health and substance use. In partnership with Newfoundland and Labrador Health Services, community organizations and peer-led experts, services are delivered using a harm-reduction, recovery-oriented and trauma-informed approach through an evidence-based stepped-care model. The stepped care model aims to match individuals with the right care, at the right time, stepping up or down intensity of supports based on need, preferences and readiness of the individual to engage in services. Integrating mental health and addictions services in Family Care Teams, at the primary care level supports the stepped-care approach, enables screening, detection and early intervention, improves patient access and satisfaction, reduces structural stigma and builds provider and team competency and capacity for interventions that do not require specialist level referrals.

Integrating Specific Program Components

a. Incorporate mental health promotion and prevention into all aspects of Family Care Team health care delivery by supporting individuals to self-manage their mental health, and empowering them to make healthier choices, improve their physical health, and reduce their risk of disease and disability. At the population level, this can help eliminate health disparities and improve quality of life.
b. Actively promote Doorways counselling clinics, the Provincial 811 Healthline, Bridgethegapp.ca and the Provincial Mental Health and Addictions Systems Navigator as key access points to mental health and addictions services for individuals and families.
c. Incorporate peer support by people with lived and living experience within Family Care Teams where possible. This is an essential component in the delivery of mental health services that offers people encouragement and hope by looking at the health and wellness of the whole person, rather than illness and disability.
d. Ensure an integrated approach to health care when working with individuals with concurrent mental health and substance use issues, which may include the use of evidence-based screening, brief intervention and referral tools.
e. Ensure MRPs receive training and are authorized, within their professional scope of practice, to assess and treat substance use disorders, provide withdrawal management services, and provide or connect individuals to ODT services available in the community.
f. Integrate existing ODT hubs with Family Care Teams as appropriate.
g. Enable MRPs to provide screening, brief intervention and referral for mental health and substance use issues including but not limited to suicide ideation, attempts, and alcohol/tobacco/gambling/substance use.
h. Support harm reduction approaches, including the distribution of Naloxone take-home kits and safe supplies for substance use and sexual activity within Family Care Team sites.

i. Perform monitoring and surveillance of mental health and addictions issues at the local level, and share relevant data among Family Care Team members to ensure programs and services are effectively meeting the needs of individuals and communities. Ensure reporting mechanisms are in place to share this information.

Resources for Family Care Teams

All Family Care Teams should have access to the following documents, and incorporate relevant components into practice and team-based care.

- Our Path of Resilience: An Action Plan to Promote Life and Prevent Suicide in Newfoundland and Labrador
- Provincial Alcohol Action Plan: Reducing Alcohol Harms and Costs in Newfoundland and Labrador
- Supporting Recovery: Provincial Practice Recovery Guidelines for Newfoundland and Labrador
- Mental Health and Addictions Provincial Gender Responsive Standards of Practice
- Family Caregivers Provincial Practice Standards
- Provincial Stepped Care Manual
- Provincial E-Mental Health Toolkit
- Bridgethegapp.ca
- Mental Health Care and Treatment Act
- Canada's Guidance on Alcohol and Health, 2023 (CCSA)
- Advancing Collaborative Mental Health Care in Canada's Primary Care Settings: A National Quality Framework with Recommended Measures (MHCC)

Integration of Community Support Program
Preamble

Newfoundland and Labrador Health Services CSS offers services to children, youth and adults to support them to remain at home and in their communities including: nursing, social work, rehabilitation, dietetics, behavioural services, home support, palliative and end of life care, medical equipment and supplies, residential living arrangements, including personal care homes and long-term care. The program operates from a "Home First" conceptual framework, which shares fundamental similarities with the vision and attributes of Family Care Teams, and represents a shift from acute and institutional care to the enhancement of home and community-based integrated care. It is a person-centred, evidence informed initiative to support individuals with complex care needs in their own homes and communities. It also requires ensuring that clients can access the right care at the right time from the right provider. It is focused on removing barriers within regular programming and wrapping supports around people in their homes and communities. Intensive care coordination and a multi-disciplinary approach is the core of the clinical design.

Integrating Specific Program Components

Role of Community Support Social Worker

- Provide an array of services to clients in their homes including counselling, assessment, referral management, support planning, and case management for older adults and persons with disabilities.
- Investigate allegations of abuse and neglect under the Adult Protection Act.
- Facilitate the coordination of client care across program areas in conjunction with other professionals, service providers, and community resources.

Role of Community Health Nursing

- Community health nursing services are provided to individuals living in the community and include acute care services, such as home chemotherapy, wound care and intravenous therapy.
- Continuing care nursing services are also provided to clients who have chronic health conditions and require support in order to remain living at home.
- Complete assessments, therapeutic interventions, case management coordination, planning, monitoring and evaluation.

Other Considerations to Integrating with Community Supports

- Provision of primary care to patients living in residential care options within the geographical area serviced by the Family Care Team where onsite primary care is not otherwise supported (applies to homes and facilities within MHA program area as well)
- Primary care support for home-based end of life care, dementia care, and frailty assessments.
- Enhanced access and flexibility to provide in-home primary care appointments when necessary aligned with the Home First philosophy.
- Flexible and tailored team supports to ensure access for individuals and families requiring support managing newly diagnosed chronic conditions, post-acute care discharge and end of life care support.

Resources for Family Care Teams

- Home First Framework
- Dementia Care Action Plan
- Provincial Home Support Standards
- Financial Programs (see Programs Funded through the Department of Health and Community Services - Health and Community Services (gov.nl.ca)

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