As Ontario begins to launch 50 more family health teams (FHTs), new FHT leaders stand to benefit from the experiences of the 150 teams created since 2005. Based on interviews with the leadership of five successful FHTs, this article presents lessons learned by the physicians, administrators and other clinicians who introduced FHTs to their colleagues and communities.

Existing FHTs have shown that the team model for primary care can benefit healthcare providers and patients. But success has not come easy. FHT leaders have to introduce new ways of practice, novel interdisciplinary relationships, the latest technologies and a new type of care organization to their diverse communities. Team leads have relied on their vision for transforming patient care to motivate themselves and their team through these challenges.

Although each FHT’s environment and composition are unique, our interviews discovered that the critical requirements for an effective team are consistent. Our interviewees identified key lessons to help new FHT leads through each stage of their team’s development. Collected below, these lessons provide practical approaches to the following:

- Investing in educating team members, particularly physicians, about the new model of care and what changes to expect in their practice
- Defining a strategy to balance the demands of team, community and the Ministry of Health and Long-Term Care
- Building a supportive, effective team environment while introducing new interdisciplinary health professionals (IHPs)

**Brief History of FHTs**

Beginning in 2005, Ontario’s Ministry of Health and Long-Term Care created 150 FHTs across the province. In 2007, the government of Ontario committed to creating 50 more FHTs based on the first teams’ success, 19 of which were announced in December 2009.

The FHT initiative aims to provide more Ontarians with access to primary care by linking physicians with teams of health professionals, including nurse practitioners (NPs), nurses, mental health workers, dietitians and pharmacists. Increased access to primary care supports the health system by reducing the number of emergency room visits, expanding preventive care services such as influenza shots and cancer screening and providing for management of chronic diseases such as diabetes and asthma.

In business plans prepared for the ministry, the first FHTs were asked to identify the number of patients they expected to roster over the coming years and how the resources provided by the ministry would support this goal. The ministry also asked FHTs to plan to implement an electronic medical record, develop patient-centred care programs and link with other community organizations. Within these broad guidelines, each FHT was free to define the team size, composition, governance model, partnerships and program mix and to development a timeline that would best suit its community.
• Planning and preparing for future demands, through ongoing communication, evaluation and adaptation

**Methodology**

Over the past four years, FHT leaders have supported each other by sharing their experiences and ideas. This article builds on that tradition by collecting common lessons and experiences to provide a starting point for new teams. It is a set of case studies, rather than a formal study of FHT best practices.

The teams interviewed for this article represent diverse communities and settings: Kingston, rural Prince Edward County, Cambridge, Stratford and a teaching centre in Toronto. All of them have a full complement of IHPs, electronic medical records (EMRs) and a range of new care programs. Many of the interviewees have been involved formally and informally in provincial FHT leadership.

We interviewed the executive director of each team. Where possible, we also interviewed the lead physician, other IHPs and additional staff to provide a range of perspectives on the FHT. Based on the interviews, we identified common themes and concrete tactics that the teams felt had contributed to their FHT’s success. These 14 lessons learned are described below.

**Investing in Success**

FHT leads must constantly decide between competing priorities for investments of attention, resources and time. The team leads we interviewed identified three key areas, outlined below, in which early investments were consistently valuable in building a more effective, cohesive team.

**Inform Physician Team Members Early On about How the FHT Model Will Work for Them**

In their dual role as clinicians and, typically, governors, physicians’ strategic input and ongoing support is critical to the FHT’s success. Physicians who fully understand the FHT model and the opportunities it presents can participate in shaping the team’s vision for integrating new healthcare providers, programs and tools to improve their patients’ care and their own work environment.

All physicians and their staff are asked to share patient care responsibilities with new team members who are employed by the FHT, rather than directly by the physician. Practices may also be asked to help meet FHT targets by increasing their patient rosters. If roles and responsibilities are not shared early on, these pressures can create unnecessary tension. The teams we interviewed emphasized that FHT leads should not underestimate the time and effort required to engage and educate the physicians throughout FHT development.

Assigning physician sponsors to each new program area can be an effective vehicle for ongoing engagement. With minimal time commitment, these sponsors can work with the responsible IHP to review planned changes and provide a physician’s seal of approval. Engaged colleagues with positive experiences are the strongest encouragement for reluctant physicians.

**Educate the Team About IHP’s Scope of Practice and Unique Role in Primary Care**

The IHPs we interviewed emphasized that working to their full scope of practice is a rewarding advantage of employment in an FHT. For FHT leads, taking time early in the FHT’s development to learn about each IHP’s role pays off in planning, by helping to show what’s possible in program development and to draft effective, relevant role descriptions. Understanding each team member’s role also helps clinicians and administrative staff to ensure that patients see the right team member.

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<th>Profiles of Five Ontario FHTs</th>
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<td><strong>Grandview Medical Centre FHT.</strong> Based in Cambridge, the Grandview Medical Centre FHT (gmcfht.ca) has been a health service organization since 1989 and became operational as an FHT in 2006. Its team includes 14 doctors working alongside nurse clinicians, nurses, registered dietitians, social workers, a health promoter and a pharmacist.</td>
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<td><strong>Maple FHT.</strong> The Maple FHT (maplefht.ca) is based in Kingston. Its patients receive care from 19 doctors, as well as nurses and NPs, and from programs focused on health issues such as chronic obstructive pulmonary disease, diabetes, foot care, mental health and nutrition.</td>
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<td><strong>Prince Edward FHT.</strong> The Prince Edward FHT (pefht.ca) cares for patients across Prince Edward County, a primarily rural region that caters to tourists, retirees and winemakers. Twenty-six physicians collaborate with nurses, NPs, dietitians, mental health workers, specialists, a pharmacist, a public health nurse and a CCAC case manager.</td>
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<td><strong>South East Toronto FHT.</strong> The South East Toronto FHT is based in Toronto’s east end, across the road from Toronto East General Hospital and on the edge of one of the world’s most diverse communities. In addition to providing collaborative patient care, it is a teaching site for the University of Toronto.</td>
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<td><strong>Stratford FHT.</strong> The 15 doctors of the Stratford FHT have had a history of inter-professional collaboration with a dietitian, pharmacist and NP in a Primary Health Care Transition Fund pilot site. Today, the expanded team provides a broad range of care programs to patients in Stratford and Perth County.</td>
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Integrating nurse practitioners (NPs) was often particularly challenging as their role in a physician-led model was not as well understood as the roles of other IHPs. Engaging physicians, NPs, and staff in a collaborative role and scope definition process can help to avoid tension; in one case, an NP took on a focused-practice role in gynecology to leverage her unique interests and skills.

Professional college websites typically provide standard resources that describe their members’ scope of practice. One FHT successfully combines education and team building by having IHPs regularly deliver “grand rounds” presentations about their skills to the physicians and other team members.

Communicate Openly and Consistently across the Team
For FHT leads dealing with the challenges of creating a new organization, it is easy to forget to communicate outside of the leadership team. Often, communications go unanswered or unnoticed; as one team member said, you may have to use ten different communication vehicles to get a physician’s attention. But consistent communication is critical to building trust and a shared sense of accomplishment across the team.

Many of the leads reported that the bulk of their time was actually spent on communication. E-mails, faxes, meetings and hallway conversation may all be required to keep team members informed and engaged. One team uses a free service called Google Apps to provide e-mail addresses, calendars and document sharing for its team members with minimal technical support. Finally, leads must communicate directly with receptionists and other administrative staff – they play a vital role in patient care and can help to get physicians’ attention.

Achieving Strategic Balance
FHT leads must constantly balance the demands of their team members, communities and the Ministry of Health and consistently advocate for their team’s vision. Early on, many teams struggle to define a focused strategy and business plan and negotiate needed resources with the ministry. This process can stretch out over months, delaying tangible progress toward implementing the team. Our interviewees identified tactics to identify, understand and manage the demands of FHT stakeholders and team members.

Identify “Early Win” Clinical Opportunities That Address a Clear Community Need
Successful FHTs started by quickly meeting one clear goal that filled a gap in current services available to their patients. This proved the value of the FHT model and motivated FHT leads, team members and community to work for further change. For several teams, this took the form of a shared mental healthcare program involving social workers and other mental health professionals. This helped patients as mental health services had been scarce, costly and difficult to access; it also helped to reduce a large and time-consuming source of demand on family practice.

“If you just address what looks like the biggest problem, you’re probably duplicating someone else’s service.”

The best early wins meet an immediate need, enhance overall patient services and provide long-term value. One team emphasized that obvious targets may not be strategic: “If you just address what looks like the biggest problem, you’re probably duplicating someone else’s service.” A new FHT may also be pressed to respond to an external agenda – for example, one driven by acute care service downloading rather than the immediate needs of team members and primary care patients. Collaboration with community partners should be balanced by insight and data from within the team.

Prepare to Negotiate with the Ministry
Every team emphasized that FHT leads must advocate vigorously for their team’s needs when negotiating resources with the ministry. Teams were often frustrated by the lack of direction or support for funding requests. Where clear performance guidelines existed, they were not always seen as appropriate; for example, patient roster targets did not take account of full-versus part-time practices, or physicians who also worked in hospital or in specialized practice. FHT leads must take responsibility for negotiating on their team’s behalf using relevant data and effective arguments, while managing internal and external expectations throughout the funding process.

Making a strong initial case for the right resources and building the team quickly is particularly important for new teams as second- and third-year funding increases are typically smaller than expected. As one team member noted, “During every review, there will be someone looking to cut something from your proposal, but no one advocating for more.”

Think Outside Ministry Guidelines to Develop the Right Model for Your Team
Since the first FHTs were created, the ministry has significantly modified its funding process to reflect lessons learned in the first three waves. However, as every community’s situation is unique, almost every FHT has also encountered cases in which a unique model better meets patient needs. For example, one FHT faced the challenge of providing mental health services to 26,000 patients using only 1.5 full-time equivalent professionals. Rather than hire dedicated employees, the team partnered with an existing mental health provider group to provide hourly
services for up to six visits per year per patient. This partnership increased the diversity of skills available for specialized problems, with low waiting times and overhead.

Other partnerships with external organizations and individual clinicians can increase team resources and effectiveness without new ministry funding. Many teams have integrated a community care access centre (CCAC) case worker or public health nurse and collaborated with specialists on a sessional or fee-for-service basis. Established FHTs also looked to external sources of funding such as pilot programs and special projects. A diverse funding base provides unique program opportunities and supports resource stability and long-term growth.

Building Your Team
In most cases, FHTs are developed as a complement to established physician practices. Existing needs, administrative processes, staff and physical space all impact the new team’s development. The FHT leads we interviewed identified concrete approaches that have helped to introduce new people and processes to improve patient care and meet practice needs.

Registered Nurses: Immediate Support for Patient Care and Team Development
Many of the leads emphasized the value that a full complement of registered nurses (RNs) brought to the team. Because RNs traditionally have a role within family practice, they integrate smoothly and immediately help to improve patient access and relieve pressure on team physicians. One RN described how her role in the practice quickly developed from taking blood pressures and patient histories to participating in chronic disease management, patient education, preventive care and more complex physical examinations and procedures. Physicians said that expanded services such as these have become invaluable.

FHT leads also found that RNs often led the development of programs for clinical challenges such as asthma, diabetes, medication management, smoking cessation, telemedicine and spirometry, building on skills developed in nursing school and other care settings.

Attitude: The Most Important Hiring Criterion
Across the teams, successful IHPs and staff were identified with varying degrees and kinds of experience – some were fresh out of school when they joined the FHT, while others had years of hospital experience. Universally, the most important attributes for new team members were seen to be flexibility, comfort with ambiguity and willingness to take leadership.

In most cases, hiring began before any formal structure was defined for the team. There was little time or expertise available to train new team members; instead, they received a broad mandate to develop collaborative relationships and new clinical programs. Where individual initiative is combined with strategic support from the FHT board and executive, this informal approach can be highly successful. By contrast, interviewees also recalled clinical and administrative team members who left the FHT because of inflexibility and discomfort with change.

Effective Human Resources Policies Provide Focus
All of the teams said that effective policies are needed for a well-functioning team environment. Effective human resources policies set expectations for each team member; they can help to resolve or avoid unnecessary disputes and reduce the impact of professional hierarchies on team collaboration. For new team members, clear policies provide structure in which to take ownership of their contribution to the team.

Several of the teams said that “policies” may be a red flag for clinicians, particularly physicians who are used to running their own office without procedures or role descriptions. Effective FHT policies must be lean, functional and straightforward – and easy to change as the team develops. Having physician board members or advisors approve each policy and its intent can help to avoid a negative response.

EMRs: Critical Tools for Collaborative, Innovative Practice
Our interviewees emphasized that an EMR is even more valuable to an FHT than to a single physician practice. The EMR ensures continuity of care across the team, whether patients are being seen by their primary physician, an IHP at a different site or another doctor in an evening clinic. IHPs particularly valued seeing the full history of each patient as opposed to a brief referral note, and being able to securely exchange electronic messages with physicians and other team members across sites. In several FHTs, the leads use aggregate EMR data to inform program planning and evaluation.

As a result of this broad contribution to the team’s success, the challenge of implementing an EMR is worth taking on sooner than later. FHTs struggled with the burden of EMR implementation and support in the absence of dedicated support funding. Many teams split the cost of an administrative staff person dedicated to technical support between the physician group and the FHT; in other cases, a manager with a general business role was also hired for technological expertise.

Patient Triage and Care Collaboration Processes Reduce Wait Times and Team Frustration
When IHPs such as social workers and dietitians join a new FHT, they often find that their first job is to introduce themselves to each team member and develop a referral and collaboration process. With a clear knowledge of each IHP’s role, strong team communication, a targeted hiring process and an EMR, this ad hoc approach can ultimately result in a smooth process for patient care. However, IHPs reported initial frustration with the
lack of structure, which resulted in lost clinical time, inappropriate referrals and long waits for patients with critical needs.

Designing a simple communication and referral process with physicians and staff before hiring can increase the effectiveness of IHPs from day one. In one team, a decentralized scheduling process has developed into a structured triage system. A care navigator reviews new referrals each day to match patient needs to the most appropriate social worker or mental health professional. With this new process, wait times have fallen from eight weeks to less than three, with urgent appointments available throughout the week for high-risk patients.

Planning for the Future
Every FHT lead emphasized that however much they have already done, the work of building an FHT is never complete. One executive director noted, “I’ve never been in an organization where the pace of change is so constant.” The FHT must adapt as new team members join and old ones leave, new programs are developed, funding priorities shift and other health services in the community arise or disappear. Although the turbulence may seem overwhelming, established FHTs have developed strategies to adapt while maintaining overall team effectiveness.

Evaluate Your Progress and Constantly Develop Your Business Case
In the early days of developing an FHT, designing an evaluation system can seem like a very low priority. In each year’s business planning, however, FHTs are asked to justify both existing and new resources using relevant data. In particular, FHT leads should track patient roster size and IHP utilization volumes as these are key metrics for the ministry.

One FHT emphasized that an evaluation system can also be a boon to FHT leads as it provides benchmarks for team success and demonstrates where the FHT is having an impact on community needs. By evaluating its programs using EMR utilization data and clinician, staff and patient surveys, this team was recently able to close an underutilized program and move resources into a new priority, without new funding.

Share Your Accomplishments with Your Community
Our interviewees identified multiple ways in which strategic engagement and communication with their community have helped them to grow more effectively. Partnerships with other organizations such as hospitals, CCACs and public health have brought needed experience and resources to the team. Skilled community members have contributed their time to several FHTs to help develop business plans and serve on the FHT board.

Defining the FHT’s positive role within its community can provide a long-term strategic advantage. During capital development projects, for example, mayors, municipal councils, members of provincial parliament and other community members who understand the benefits of the FHT can play key roles in its success. A positive public impression also reflects well with the ministry. One FHT lead works to ensure that “any good news story is in the paper,” and encourages nurses and other team members to contribute regular health columns.

Be Prepared to Constantly Iterate and Adapt
Ultimately, every team emphasized that good planning goes only so far – adaptation is the final determinant of success. Some teams had implemented every part of their initial business plan, while others had completely changed their strategy; but they had all dealt with a wide range of unexpected issues and opportunities. Dealing with change was a challenge for FHT leads, but as one team member pointed out, it can also be a benefit – early mistakes can easily be corrected.

To ensure that teams stay on the right path, our interviewees encourage short planning cycles combined with constant evaluation and adjustment. All team members should be prepared for constant change and be ready to take initiative. IHPs and leads have benefitted from training in process mapping and a structured improvement methodology such as Plan-Do-Study-Act cycles. Regular communication and data sharing across the team ensure that individual contributions support the overall strategy.

Getting Started
The FHT leads we interviewed had many stories about the difficulties they faced early on. As one physician recalled, “We knew nothing about business and were in way over our heads.” To develop their successful teams, they had to define their own vision, learn new skills and experiment constantly. Today, none of them would want to go back.

New FHT leads can benefit from the experiences of these leaders to help set priorities, adopt effective approaches to FHT development and overcome early challenges. We recognize that the topics covered here are not exhaustive; for example, this article does not address governance, capital planning or program development. All our interviewees said that new FHTs – and existing ones – should continue to reach out to other teams for help and practical advice.

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About the Authors
Nick Ragaz, BA, Courtyard Group, Toronto.
Aaron Berk, MS, MHSc, CHE, Toronto.
David Ford, MHSc, Courtyard Group, London, UK.
Matthew Morgan, MD, FRCP(C), Courtyard Group, Toronto.

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