Thompson Region
Division of Family Practice
A GPSC initiative

GPSC
General Practice Services Committee

Early Findings on Collaboration to Foster Family Practice (FP) Networks

Case Study Report from Thompson Region Division of Family Practice

February 2019

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Executive Summary

Overview

As Divisions of Family Practice across the province support the implementation of the Patient Medical Home (PMH), there will be an increasing need to identify and operationalize enablers of the attributes of the PMH. The Thompson Region Division of Family Practice (DoFP) is in the process of building capacity for FP networks, and the relationship that it has built with the Practice Support Program (PSP) is one example of an enabler.

By working closely with the Thompson Region Division, PSP has become a key stakeholder and filled a previous gap in the local primary care planning team. Its on-the-ground knowledge of both the practices and their panel data, along with the trust that PSP teams have developed with these practices, has created a working relationship that will streamline future networking activities. Additionally, as the Thompson Region and other regions move forward with FP networking activities, there are several structural, operational, and relational enablers that can be considered.

Recommendations to Further Enable FP Networking

The recommendations below are derived from the key learnings that came from the Thompson FP network development case study. At the end of each recommendation is a reference to the finding from which the recommendation was derived.

Recommendation #1 - *Identify approaches to integrate existing and new resources into groups that local FPs trust and value.* Local FPs have developed a relationship with PSP team members and trust PSP's ability to advocate and support their needs so that they can provide the best care to the patients they serve. Project management support from DoFPs can help to optimize the integration of provincial supports, like PSP, into networking activities. Each community may have different approaches to how these relationships can be structured. *(See Finding # 1)*

Recommendation #2 – *Communicate early successes from other FP networks as they are identified.* The provincial move towards FP networks and a more integrated approach of delivering primary care represents a relatively new way of providing primary care in some communities. It is valuable to communicate the benefits of proposed changes to all stakeholders to facilitate buy-in. While communication of successes will facilitate engagement, it must also be recognized that there is no one-size-fits-all approach to FP networking. Certain

approaches that work well in some communities may not be feasible in others. (See Finding # 6)

Recommendation #3 – *Develop tools that can be used to support FP networking.* Several tools such as template memorandums of understanding, evaluation tools to assess readiness to collaborate, business planning templates, and information sharing agreements could be consolidated into a single networking toolkit. These tools would optimize how networks are developed and reduce the duplication of efforts that are inherent in the identification and development of such resources. *(See Findings # 4,5,6)*

Recommendation #4 – *Identify methods to continue to compensate physicians for their investment in networking activities while ensuring that support is available to address activities that are outside physicians' expertise*. This case study identified that most physicians do not have the interest nor the expertise to manage networking activities. While they may be able to identify opportunities and to guide implementation of a given activity, there continues to be the need for personnel that have the background and experience to manage the day-to-day components of this work. To make the best use of physician time, General Practice Services Committee (GPSC) and local Divisions should aim to identify areas and activities best managed by non-physician personnel, and subsequently recruit the appropriate individuals. As well, both entities should jointly identify the activities best led by physicians, and provide compensation that recognizes FPs' contributions. (See Finding # 2)

Recommendation # 5 – *Be persistent in evaluating the FP networking activities to determine the extent to which they are sustainable*. The interviews conducted with local physician stakeholders identified that there is a lack of clarity about the sustainability of supporting network activities under the current Fee-For-Service (FFS) payment model, specifically during the transformation of primary care towards a comprehensive approach to care. The interviewed physicians recognized that to date, communications provided to them on comprehensive models of care may be better for patients, but may not be sustainable to the public system under the FFS model. They further suggested that the positive impacts of certain network activities may not be seen immediately, and thus the evaluation of these approaches must consider short, intermediate and long-term impacts of these investments. While cautiously optimistic about transitions towards comprehensive approaches to the delivery of primary care, those interviewed highlighted the ongoing need to monitor the sustainability of such changes. (See Finding # 3)

Conclusion

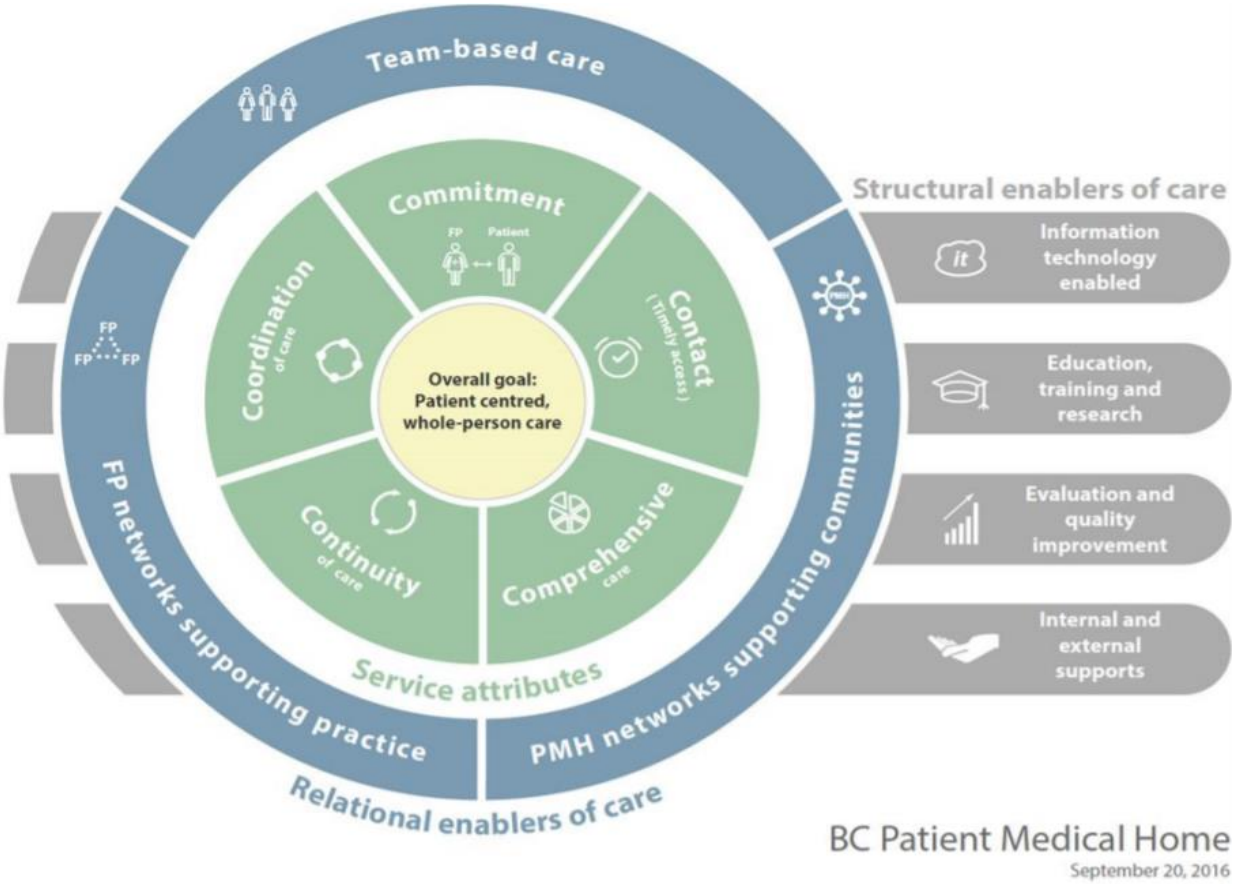
FP networks, when implemented effectively, have a significant positive impact on patient care. The successes of developing and implementing these networks moving forward depend largely on planning, shared visions, support, and intentional efforts and processes to communicate, build and maintain trust. GPSC has the opportunity to support, build and communicate this and other enablers of care to help foster the development of FP networks across the province.

Context and Background

The BC Patient Medical Home Vision

In BC, the Patient Medical Home (PMH) is the vision for the future of family practice (FP). The PMH offers comprehensive, coordinated, and continued care to their patients through a family physician working with health care teams.[1] The attributes and enablers of the PMH have been defined in the BC context and are summarized in Figure 1 below. One of the relational enablers of care is FP Networks supporting practices. In the PMH, FPs are part of a clinical network that collaborates to meet the comprehensive care needs of patients and the patients of other PMHs in the community, including extended hours of service, cross coverage, and on-call services.[2]

Figure 1. The Attributes and Enablers of the Patient Medical Home in BC[2]



[1] Adapted from The Patient's Medical Home (Canada) Accessed online at: https://patientsmedicalhome.ca/why-pmh/ on September 5th, 2018.

[2] Patient medical home in BC (Published by the GPSC), Accessed online at: http://www.gpscbc.ca/sites/default/files/PMH%20graphic%20%2020160920.pdf on May 12th, 2018

Collaboration between PSP and the Thompson Region Division of Family Practice

In November 2016, an Expression of a Working Relationship and a strategic plan were developed between the Practice Support Program (PSP) and the Thompson Division of Family Practice (DoFP). This expression was directed towards improving FP's capacity to form Primary Care Networks (PCNs). It was anticipated that this collaboration would enhance the strengths of both the DoFP and PSP. Since the formalization of a working relationship between these two groups, it was identified that this collaboration has the potential to support the development of FP Networks.

As such, this case study reviews:

1. How the working relationship between PSP and the DoFP at a community level can support an environment of collaboration, which in turn enables the development of FP Networks.
2. How the PSP and the DoFP can work together with local FPs to create a shared vision for networks across Family Practices.
3. How the PSP and the DoFP can support the structural, operational and relational enablers for developing Networks.

The FP network activities that were discussed through the interviews in this case study focused primarily on activities that allowed physicians to develop call or cross-coverage groups for specific matters like extended hours of service. This would allow physicians to work in networks that could produce referral trends to enable networks to have areas of focus, and for network members to share staff and other resources, such as allied health personnel, with their colleagues. Although there may be additional networking activities that are important to other groups across BC or that will become of value to the Thompson Region in the future, they were not an area of focus within this case study.

While this case study reflects the current state of the Thompson Region, its findings have the potential to be relevant to other communities across BC. Not all regions currently have the same type of formal working relationship between the DoFP and PSP as the Thompson Region. However, if the PMH vision is to be realized in BC, collaboration is needed to develop approaches that support the development of FP networks. Thompson Region's approach and the learnings provided within this report can help enable such collaboration.

Overview of Case Study Approach

This case study employed four broad approaches to understand how PSP and the DoFP are working together to support the creation of networks. These approaches included:

1. A review of local documentation that focused on the relationship structure and current work taking place to support the development of FP networks.
2. A literature review which reviewed over 50 research articles, policy and position documents, guidelines, and best practices to focus on understanding how other groups across Canada and the developed world have worked together in primary care to create networks within primary care. These findings are available in *Appendix 3*.
3. Interviews with key stakeholders at a local, regional and provincial level to understand the various factors (i.e. political, environmental, technological, legal) influencing the development of FP networks in the Thompson Region and BC more broadly. The list of individuals interviewed is included in *Appendix 1*.
4. A survey of the members of the Thompson Region DoFP which asked questions on their current levels of networking and areas for which they see opportunities to network.

The following pages compile the key relevant findings across these activities as it pertains to the development of networks.

Case Study Findings

Finding #1 – The relationship between PSP and DoFP fosters an environment of collaboration thereby supporting the development of FP Networks.

The Expression of a Working Relationship prepared by the DoFP and the PSP was created specifically for supporting the transformation toward the development of Patient Medical Home initiatives. The core components of the expression, which reflects expectations of PSP, is described in *Appendix 2*. The design and intent of this working relationship truly integrates the PSP coordinators within the DoFP team. Integration is reflected in numerous ways such as through the visual representation of PSP coordinators as team members on the DOFP's website[3], their frequent presence at the DoFP's office, and their regular attendance at a range of related working group meetings. Through the physician interviews it was communicated that this integration is so seamless that many local physicians view PSP and DoFP as the same entity, providing wrap-around support for the local delivery of primary care. Survey responses also confirmed that PSP team members were a valuable part of the team. Locally, this provides an advantage as the relationship and FPs' perceptions of the DoFP in the community are stronger and more positive than that between FPs and other government

[3] See: https://www.divisionsbc.ca/thompson/team last reviewed March 30th, 2018

bodies. The FPs recognize that the DoFP represents their interests because PSP team members are functionally working together as an extension of the DoFP team. As a result, trust has been established that PSP team members will represent the interests of the FPs.

This integration of PSP team members into the DoFP provided several additional advantages. For example, the regular interaction with FPs through panel management work along with attending strategic planning meetings has provided PSP team members with knowledge on areas that could be operationalized into network-related activities and other division-related activities. Interviews with PSP team members focused on how their formal relationship with the DoFP supports the panel management work, and explored how panel management work may ultimately support FP network development. Through this, PSP team members have developed an understanding of practice area interests of local physicians.

PSP's involvement with both the clinics and DoFP strategic planning activities allows for the bi-directional exchange of ideas across local physicians and the DoFP, and exposes areas where there may be opportunities to develop FP networks. When consulting with physicians, the PSP team members identify the data interests of the FPs , and use this knowledge as a starting point to garner the practice's interest in working with PSP to clean and manage their panel. This grassroots approach has supported local physician buy-in to do panel management work. While the appeal in panel management work is diverse across FPs and can include interests like the desire to understand their practice makeup, aspirations to improve upon incentive based coding for billing, and hopes related to data quality after a migration to a new EMR, some of the interests are specifically for assessing the feasibility of implementing FP networks. For example, the panel review process has begun to encourage discussion on how FPs may be able to work with colleagues to share a nurse in their practice, or to identify the numbers of patients with a specific condition so that they can work with colleagues to better support the management of this patient population. Once these interests are identified and physicians understand the support that is available for this process, they demonstrate interest in moving forward with the work. While the physicians are the ultimate stewards of their panel data, this working relationship gives PSP team members both the understanding of the panel information and an awareness of interests across practices.

This approach to panel management does require a significant time investment from the PSP coordinators. However, based on interviews with regional and provincial stakeholders, a successful approach to beginning discussions about networking involved first, raising awarness about how the FP currently used their panel data and the potential value of reviewing and understanding their panel data. These steps helped to facilitate buy-in and helped FPs to start identifying opportunities for further use of panel data for system improvement. PSP team members are also integrating the Specific Measurable Achievable, Relevant and Time bound (SMART) action planning process for panel work, which gives FPs ownership over improvement activities. PSP also communicates ongoing DoFP initiatives that are happening within their regions. Collectively, these activities provide value to the physicians that they serve, and further support the common goal of having useful panel data that can be used by FP networks.

Additionally, the close relationship that PSP team members have with FPs provides program staff with both the knowledge to connect physician groups with shared interests, and as well, gives DoFP and Interior Health (IH) stakeholders a clear understanding of local priorities and interests on project areas that are being considered regarding network development. Consultation with the DoFP stakeholders verified that, because of the Expression of a Working Relationship between the two groups, PSP team members are more involved in PMH work. Involvement of PSP team members was also bolstered because of their use of the DoFP office space. Lastly, PSP team members are present at semi-monthly meetings involving both IH and DoFP. This provides all parties involved with an understanding of how physician panels can be used to guide and inform initatives and FP-driven local priorities. It is this knowledge that is available from panel management work that helps to pave the way for other FP network and PMH development activities.

Further, and as described by DoFP and IH stakeholders, PSP team members have a professional background unique from the FP and traditional IH or DoFP administrators, and experiences from related roles that address a technical ‘gap’ which often exists in strategic and planning meetings. Consider, as an illustrative example, a physician group coming together and working with the health authority and DoFP to identify how they could share resources to integrate diabetes education practice support into their practices. PSP team members have the technical capability to work with the physicians to quantify how this resource would be divided across practices based on their panel make-up, while the project lead for the health authority and DOFP would work with physician groups to clarify the nature and scope of work to be performed by an educator, and forecast the number of patients a

given educator could manage. Such planning, if done optimally, requires this hand-in-hand collaboration between groups that can review panel data and those that can operationalize it into an initiative.

As such, all parties involved have long-recognized that this close relationship between PSP and DoFP creates a collaborative environment. While it requires some accommodation and balancing of priorities, this approach allows these two groups to work in tandem, enhances communication across the community, avoids duplication of efforts, and overall leads to improved delivery of services directed towards the development of FP Networks in the Thompson Region.

Finding # 2 – Ongoing collaboration between PSP and DoFP and FPs is required for the continued development of formal network activities.

Based on the interviews conducted and the literature reviewed, the development of FP networks as envisioned by the BC PMH model will require several ongoing supports. This includes:

- Continued progression towards high quality panel data and clinical information sharing strategies;
- Individuals, independent of the FPs, like PSP team members who expertly interact with EMR technologies and are familiar with reviewing and analysing EMR data;
- Individuals, independent of the FPs, like DoFP project managers that can develop business plans, implement network related projects and evaluate the impact of these iniatives; and
- An engaged physician workforce that is adequatly compensated for work that they are involved with, and who see the value in such work both for themselves and for the patients that they serve.

Therefore, in addition to ongoing panel work that will make this type of work technically feasible, there is the need for (1) PSP coordinators, (2) DoFP personnel and (3) engaged physicans to work closely to facilitate such activities. The lack of engagement of any single group will limit the successes of developing such networks.

For example, during the interviews, the physicians communicated that their priority is first and foremost patient care and without PSP team members or other related staff that have the technical expertise to review and analyze their panel data, that panel work would be difficult to complete. Even physicians that have the technical abilities to review their panel data expressed that this work is out of their scope of expertise and believe that their energy should

be focused on providing care to patients. According to the physicians, the DoFP has a history of securing funding, managing initatives and bringing multiple stakeholders together for community-based projects. Through the data collection process it became evident that the physicians involved not only need to be interested and involved in leading networking activites, they must also assume responsibility for the patient panel data. Therefore, as the stewards of these data and the individuals familiar with its validity, the physicians described that they have the responsibility to ensure that the information is being used appropriately.

Finding #3 - FP Networking Opportunities in the Thompson Region

Several network activities have taken place in recent years. A survey that obtained results from 60 DoFP members (roughly 70% of FPs practicing in a primary care setting in the Thompson Region), highlighted several key findings that demonstrate continued interest, development of and potential for FP networking activities:

- 45% work in a group practice and 60% report professionally connecting (networking) with 6 or more physicians on a weekly basis (*see Table 2*).
- 24% have completed panel assement activities with PSP.
- 25% indicated an interest in joining a physician/community approach to disaster management. This network would assist those who have been affected as a result of wildfires, floods, and other emergencies.
- There is an interest in further expanding team-based care activities which will require the sharing of resources across practices and at various other levels. For example, only a few respondents currently have a nurse in their practice (21%) or a counselor in their practice (10%). However, almost 50% would like a nurse in their practice and nearly 65% expressed their desire to have a counsellor in practice. As well, close to half of the respondents were interested in resources like pharmacists, physiotherapists and dietitians (*see Table 1 below*).
- Furthermore, approximately 60% of physicians indicated one or more age demographic areas of interest that they enjoy practicing within (*see Table 2 below*). Additionally, while many individuals enjoy being a full service practice, most also prefer to participate in other activites such as obstetrical work, pain management, musculoskeletal medicine, mental health, and diabetes management. Within each of these areas, there are opportunities for further networking across FPs to enable physicains to provide care in these areas to which they have both an interest and often higher levels of training.

Figure 2: Survey responses to How many other physicians do you professionally connect (network) with on a weekly basis

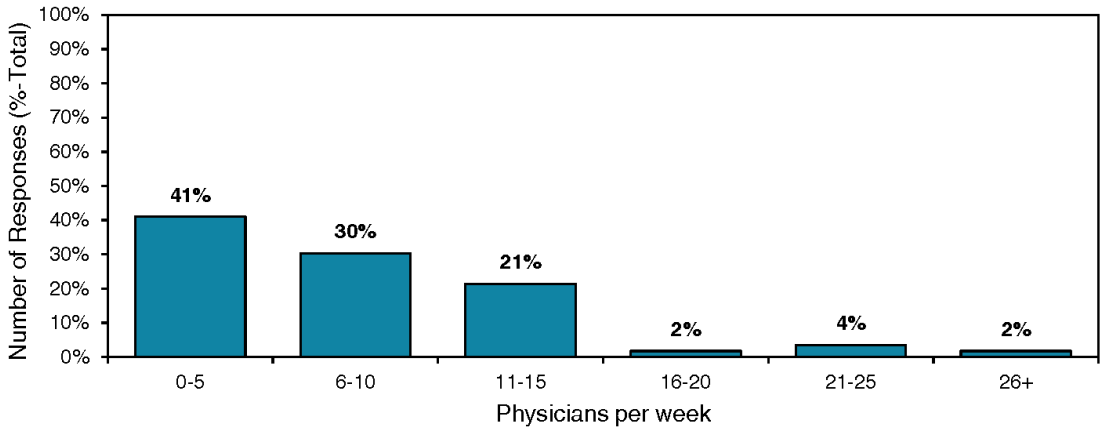


Table 1: Survey responses to: Your ideal family practice would include the following staff/resource:

Type of Team Member	N	%
MOA	54	93%
Office Manger	37	64%
Counsellor	37	64%
Registered Nurse	28	48%
Physiotherapist	28	48%
Pharmacist	24	41%
Dietitian	23	40%
Respiratory Therapist	18	31%
Nurse Practitioner	16	28%
LPN	13	22%

Table 2: Survey responses to: Demographics that you would be drawn towards

Area of interest	N	%
No specific demographic areas of interest	23	40%
Older Adults	18	31%
Complex Patients	18	31%
Women's health	16	28%
Mothers and newborns	15	26%
Children	11	19%
Teens/Young Adults	10	17%
Men's Health	6	10%

Table 3: Survey responses to: On what matters would you like to connect with other physicians

Areas interested in Networking	N	%
Sharing a pool of locums	24	41%
Sharing patients	18	31%
Sharing business ideas	18	31%
Quality improvement opportunities	15	26%
Sharing a business manager	11	19%
Sharing a pool of MOAs	10	17%
Sharing purchasing power	9	16%
Not interested in these network activities	14	24%

These results indicate three distinct areas where networking activities could be focused: (1) There appears to be **local interest in identifying ways to support more nursing, counseling, and physiotherapy services in practices,** and it is likely that some of these practices would not be able to support these roles in a full-time capacity. (2) There also appear to be **groups of physicians that have preferences working with specific populations**. While interviews have indicated that some FPs will always prefer comprehensive care across all stages of life, further engagement and review of their current panels may identify opportunities to pair up practices or groups of pratices, or to support a community-based referral process for new patients to allow for focused areas of care. (3) There is an interest in specific networking activities, especially in **sharing locums**.

While the membership survey has identified several areas where there are opportunities for further networking, some hesitations or concerns were identified during interviews that will need to be resolved for this work to progress optimally. To optimize the use of shared resources (such as allied health) in a network, there needs to be a shared vision for this work across both providers and government stakeholders supporting such work. One of the physicians interviewed described their experience working in Alberta where such networking activities had been established. According to this physician, one of the key challenges to sustaining this model was finding a shared vision.

Additionally, the physicians interviewed describe that they are accustomed to working independently and the provision of team-based care changes this dynamic. Physicians often choose to pursue a career in family practice because they enjoy the diversity of work that it provides and, for this reason, further referral of their patients to colleagues in focused practice or to networks of allied health may not be universially supported.

Furthermore, there are some hesitations on the extent to which these activities can be implemented in a cost-effective manner. For example, traditionally patients schedule an appointment with an FP when they are ill or believe they require some aspect of their health to be reviewed. Team-based activities such as the sharing of a diabetic nurse educator or a counselor would likely involve clinics following-up with their patients on a regularly scheduled basis. Currently there are opportunities to communicate this transformation as it has been recognized at the clinical level this is a fundamental shift how primary care is to be delivered. Physicians will need to know how an increasingly comprehensiveand expensive system of primary care will be sustainable to the public system. For example, it was suggested that such a transition where care is, in essence, marketed to patients, could transition networks into businesses where profit generation is prioritized. This is a risk and concern that will need to be addressed and communicated to primary care providers.

It was also described that, while it is excellent for the patient to be able to access comprehensive care, if such programs are to be implemented they must be evaluated, and considerations provided on whether publicly funded healthcare can sustain such a model of care. It was suggested that other provinces have tried and failed to sustain this type of comprehensive care model, and that BC should learn from these other jurisdictions. There is an inherent challenge that can come with evaluating these networking strategies, for example, in order to decide what types of networking should be supported, the perceived value of the networking activity should first be identified. Determining this will be somewhat difficult and will need to focus on activities rather than outputs, as outputs such as the reduction in diabetic-related mortalities take time (e.g. ten years or more) to be realized.

To build upon the interests that were identified by physicians, and to overcome and address several of the challenges that were identified through this consultative process, the following pages highlight how the Thompson Region, PSP and other DoFPs can work with their FPs to further enable the development of FP networks.

Finding #4 - Structural and Functional Enablers of FP Networks: business plans

There are several formal, structural and functional activities that can enable further development of how FP networks and teams are formed and include consideration of the organizational arrangements of the team, team composition, location, technological support and funding. The literature reviewed highlighted that it is essential for groups to start early with consideration around any resource and financial impact of implementing this network.

The formal business relationship between providers should be part of the discussion early on, as there are a variety of approaches that can be taken based on the level of independence, risk, and responsibility for which different physicians have interest. This can be achieved by translating these considerations and overall visions into a business plan. These will help an FP network reach its ambitions within specified timelines. They also clearly set expectations and ensure that the resources that are needed to give wrap-around support to these networks are identified. The development of such a plan often requires individuals with business and organizational development skills that can provide additional capacity to manage the workload associated with practice changes. There was consensus across individuals interviewed (FPs, DoFP, and PSP) that the DoFP is best suited for supporting the development of these plans. Furthermore, while physicians may have some interest in being involved in such work (if they are appropriately compensated), formal network planning is a new way of working that will require FPs to change how they run their practices, and a business plan can help streamline this change.

Business plans should aim to: (1) help ensure that individuals have a shared vision, (2) ensure that the appropriate experts and resources are available for work, and (3) identify strategies for monitoring the progress of such work. While developing business plans, it is important to highlight that some level of flexibility should exist, as networking often occurs naturally and fluidly.

Finding #5 - The Operational Enablers of FP Networks: ensuring buy-in and supporting collaboration

This dimension focuses on how the processes and mechanisms used to conduct activities within a team or network influence the successes of a network. These include guidelines, protocols and directives, meetings and collaboration, shared plans and the establishment of formal routines.

Both interviews and the literature highlighted that the feasibility and success of networks are highly dependent on the stakeholders involved and the environments in which these networks operate within. It was described both in the literature and by interviewees that if interest cannot be established across groups, the work should not be further considered until receptiveness to networking improves. There are several operational enablers that can help to both identify the extent to which there is an interest in and readiness for collaboration along stakeholders, and ways by which interest can be built. Formalizing the collective planning process, such as through a business plan, may support the development of a common vision.

However, stakeholders identified that the process of building a business plan alone may not be enough to formalize vision. Efforts should be made to facilitate a “bottom-up” or grassroots approach to consensus-building among stakeholders. The local approaches taken must allow and encourage the FP Networks to focus on the needs of their physicians and patients.

While there is a no one-size-fits-all approach, there are several operational factors that identify buy-in and the extent to which a given group is likely to collaborate towards a common objective. Also, and as a means of supplementing the business planning processes, several tools can help to identify readiness and willingness to collaborate. For example, the Wilder Collaboration Factors Inventory is a practical tool for discovering how a collaboration, network, or team is operating on the 20 factors that influence success. The inventory takes about 15 minutes to complete online,[4] and results can help identify areas where further discussion may be needed regarding buy-in or the resources required for successful implementation. The pre-evaluation of a potential initiative can help to identify areas where attention must be focused to build consensus or to predict the likelihood of successful networking activity.

While the Wilder Collaboration Factors Inventory is one specific tool that can be used for this purpose, there may be a benefit in modifying it to the context of FP networking or exploring other tools such as Bodenheimer’s interprofessional chronic care model which includes six components for assessment: self-management support, clinical information systems, delivery system redesign, decision support, healthcare organization and community resources. Alternatively, Butt’s model on partnership effectiveness can be evaluated using two external process measurement tools: the Partnership Self-Assessment Tool and the Team Climate Inventory. The essential factor to consider is not necessarily which tool is used, but rather the extent to which stakeholders are interested and able to collaborate on the network activity of interest.

[4] See: http://wilderresearch.org/tools/cfi/ accessed online June 10, 2018

Additionally, the interviewed FPs described that they would benefit from formal learning sessions and professional development support to enable the practices and organizational changes that come with networking. This support should be in addition to funding specific project time for selected clinicians, and could build upon the CME activities and process that are already in place.

Finally, although the ideal EMR and IT solutions that allow sharing of patient information across providers may not be immediately available, continued efforts towards access to technological solutions will be necessary to enable the implementation and maintenance of these networks' functionality. Those groups interviewed that have been successful in standardizing EMR platforms across providers appear to be ahead when it comes to the implementation of data-driven evaluation and quality improvement activities. Ultimately, by sharing functions over a single platform, economies are generated with support practice expenses and mean overhead costs are minimized. These economies of scale reduce administration and staff costs while helping to expand the sharing of good practice, and this is what makes FP networks so appealing to many FPs. In the interim, strategies that focus on increasing the appropriate transfer of patient information across stakeholder groups will help to enable network activities.

Finding #6 - The relational enablers of FP networks: structuring communication and formalizing relationship expectaions

These enablers focus on how the professional and interpersonal patterns of the team--such as leadership and ownership, respect and trust, sense of belonging, team climate and the establishment of routines--influence the successes of a network.

This case study began because it was identified that formal collaboration between PSP and DoFP supports the activities required to enable the development of networks. The impact that this formal collaboration had was seen not only at a local level, but also beyond the Thompson Region, as the process of multi-stakeholder groups becoming increasingly interested and invested in FP network activities is a new priority in BC. The Thompson Region case study shows that the process and commitment to developing and maintaining a formal relationship with other parties for a common objective like building networks expedite progression towards this objective. For this reason, formal tools that identify the nature of the relationship between two or more parties can have value in moving groups towards this common goal.

Terms such as *agreement*, *memorandum of agreement*, *contract*, and *memorandum of understanding* may all have the same broad purpose, but it was identified that they have different meanings to different parties involved. Regardless of the terminology used and specific tool applied, the focus in this context should be on going through a process of setting responsibilities and mutual expectations across stakeholders. While such methods may need to be formatted in a matter that addresses any concerns that a party has about the extent to which an agreement legally binds another, it was identified that there may be value in beginning this process by focusing on capturing the anticipated contributions of each party rather than the repercussions of non-adherence to the agreement. Regardless of how they are defined, these initial agreements can be communicated as an expression of a working relationship and can set the stage for an intentional collaboration.

While the language *memorandum of understanding* or *expression of a working relationship* may be perceived as being less intimidating and threatening than *contracts* or *agreements* and may avoid any perceived legal commitment or legally enforceable agreement, as relationships evolve there will be the need for more formal tools to set expectations between groups. The interviews conducted with FPs highlighted the benefits that have come as a result of the trust that has been built between PSP and their practices, and how they have developed a good working relationship with the Division in recent years. However, one of the barriers to such collaboration at a broader level is the willingness of practices to share their data and information with government bodies.

Many networking activities will require sharing of data. Physicians that manage their own practices are the stewards of their EMR and panel data and they are deeply cautious about unconstrained sharing of such information. Additionally, there are also extensive privacy laws around health data to comply with, risks that data will be used to compare them to their colleagues, concerns around data validity, and perceived risks that such data will be misinterpreted. For these reasons, such practices are not currently willing to completely provide access to this information to groups like the Division or the Health Authority. However, because trust has grown between these practices, PSP and the Division in recent years, there have arisen opportunities for practices to work with these groups to share specific components of their panel data for ordinary purposes. These include the further development of networks, or determining resource needs, so long as these purposes are clearly defined and expectations are laid out and documented, such as through an information sharing agreement or protocol. These types of agreements are increasingly used in the healthcare setting and set a framework for the secure and confidential obtaining, holding, recording,

storing and sharing of information between participating groups and principles about sharing personal or confidential information.

Some of the hesitancies around data management and distribution of this information could be avoided with the co-development of a business plan specific to a networking activity and the increasing level of trust between parties. Additionally, formal agreements, such as an information sharing agreement, may enable further willingness for physicians to share their panel data. There may be value in identifying whether agreements will be for an ongoing purpose (such as networking) or limited to a specific networking activity. Many of the current templates that exist in BC for particular activities have been designed for the sharing of patient-identifiable information. While some networking activities may require an agreement that anticipates sharing of patient-identifiable information, some information sharing activities, such as the review of select de-identified panel information to quantify the number of diabetic patients within a network for resource planning, may be able to be performed without acquiring patient-identifiable information. In the example provided, the data elements and use of data made be defined more precisely and limited in scope, so as to address physician concerns while enabling the networking activity.

An important relational enabler of network activities is the development of a communications plan. A communication and knowledge translation strategy can allow for:

(1) proposed network activities to be communicated across a given community to identify other FPs that may have interest in the networking activity;

(2) to communicate initial wins to build morale and momentum to demonstrate immediate systemic benefits to practitioners at a community level; and

(3) to communicate early findings to across the region and the rest of the province so that other groups can consider whether or not a given network activity is of value to them.

When interviewed, the PSP team members highlighted that one of the advantages that they have is a familiarity with how panel data can be used to support networking based on initiatives being done across the provinces and they also are familiar with networking interests of local FPs. Their involvement will also be crucial to developing communication strategies.

It was identified during interviews and the literature review that a communication strategy is more than the unidirectional flow of information, but rather should include approaches to support continued conversation and self-reflection. Some practices appear to have daily or weekly huddles across members of their team which allowed each member to provide feedback and to highlight successes as well as identify and address matters that are or are

not working. Regularly scheduled meetings within a network, where all members welcome feedback, could allow for early identification of issues and therefore has the potential to lead to efficiencies. However, both the literature and interviews identified that many FPs have historically worked within an autonomous practice and open conversation may not occur naturally until it becomes routine. Furthermore, just as practice huddles involve all members of a practice, FP networks should ensure that there is timely and clear communication between the project team, each of the practices, and the other organizations influenced by the network, including all non-physician staff affected in a given practice.

Conclusion

FP networks, when implemented effectively, have a significant positive impact on care. However, as described above, the successes of these networks depend primarily on planning, shared visions, support, and intentional efforts and processes to communicate and build trust in new models of working where government stakeholders have not previously been involved. The specific activities that the Thompson Region has undertaken in recent years may provide perspectives to other groups and regions that are interested in supporting and building upon FP network related activities. This review also provides the Thompson Region with areas that it may consider focusing its networking activities and supports in the future planning. Finally, through this review and engagement with local and provincial physicians, project coordinators, managers and administrators, several structural, operational and functional enablers of networks have been identified. These include, among others, the use of tools and processes such as business plans, collaboration readiness assessment tools, expression of a working relationship, and information sharing agreements.

Appendix 1 - Stakeholders Interviewed

List of interviewees	Title/Role
Monique Walsh	Executive Director, Thompson Region DoFP
Shelley Breen	Project Manager, Thompson Region DoFP
Joanne Styles	Coordinator, Thompson Region PSP
Ron Gorospe	Coordinator, Thompson Region PSP
Dr. Alina Crib	Family Doctor, Kamloops
Dr. Selena Lawrie	Family Doctor, Kamloops
Dr. Chip Bantock	Family Doctor, Kamloops
Julius Halaschek-Wiener	PCP Lead, KB Region DoFP
Andrew Earnshaw	Executive Director, KB Division of Family Practice
Tracy St. Claire	Executive Director, SOS DoFP
Dr. Brenda Hefford	Doctors of BC Executive Director, Community Practice, Quality & Integration, Family Doctor, White Rock
Jaime Shipmaker	PSP Lead, Interior
Ian Hodder	Manager, Change Management, Clinical Information Programs at Newfoundland & Labrador Centre for Health Information
Glenda Nash	Program Director, Family Practice Renewal Program Newfoundland and Labrador, Canada

Appendix 2: Scope of services provided by PSP as per expression of a working relationship

A. PSP will provide 2.0 FTE PSP Coordinator support for the DOFP Transformation/PMH Initiative.
B. PSP Coordinators will be based in their current location (IHA office) with the option of utilizing office space at DOFP when needed.
C. PSP Coordinators will attend PMH Divisions meetings when available.
D. PSP Coordinators will continue to attend PSP related meetings and training sessions.
E. PSP Coordinators priority will be EMR panel management clean up. This will be completed by December for the first phase.
F. DOFP and PSP will decide together which family physicians will be engaged for EMR panel management clean up and when that work will be done.
G. PSP Modules will be at the request of Division membership and in consultation with DOFP.
H. In-Practice support will still be made available for family physicians who are not directly involved with the Transformation/PMH Initiative. This will be done in consultation with Divisions.
I. Peer mentor support will still be made available for family physicians who are not directly involved with the Transformation/PMH Initiative. This will be done in consultation with Divisions.
J. PSP will not collect, or store data related to EMR panel management clean up. Responses or actions to any requests for this data will be the responsibility of the physician.