

UNSW research centre for **primary health care and equity**

Teamwork and Team-Link: What difference did we make?

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Background

1. Patient care teams a key element of chronic illness model
2. EPC and practice nurse initiatives have promoted the idea of patient care teams
 - within the practice
 - between practices and allied health providers.
3. Our“Prac-cap” study demonstrated association between teamwork and quality of care for patients with chronic illness in general practice.
4. Planned care associated with improved outcomes for patients with poorly controlled diabetes in Australian general practice
5. Studies in Canada have demonstrated the effect of facilitating teamwork on quality of preventive care in family practice.

Evidence-practice gap

- Low level of engagement of practice nurses and other non GP staff in chronic disease management in general practice
- Poor understanding of each others' role
- Poor communication between GPs and nursing and allied health providers outside the practice
- Low rate of referral to allied health
- Low levels of attendance when referred



Study questions

1. What impact does relatively low intensity facilitation and training have on:-

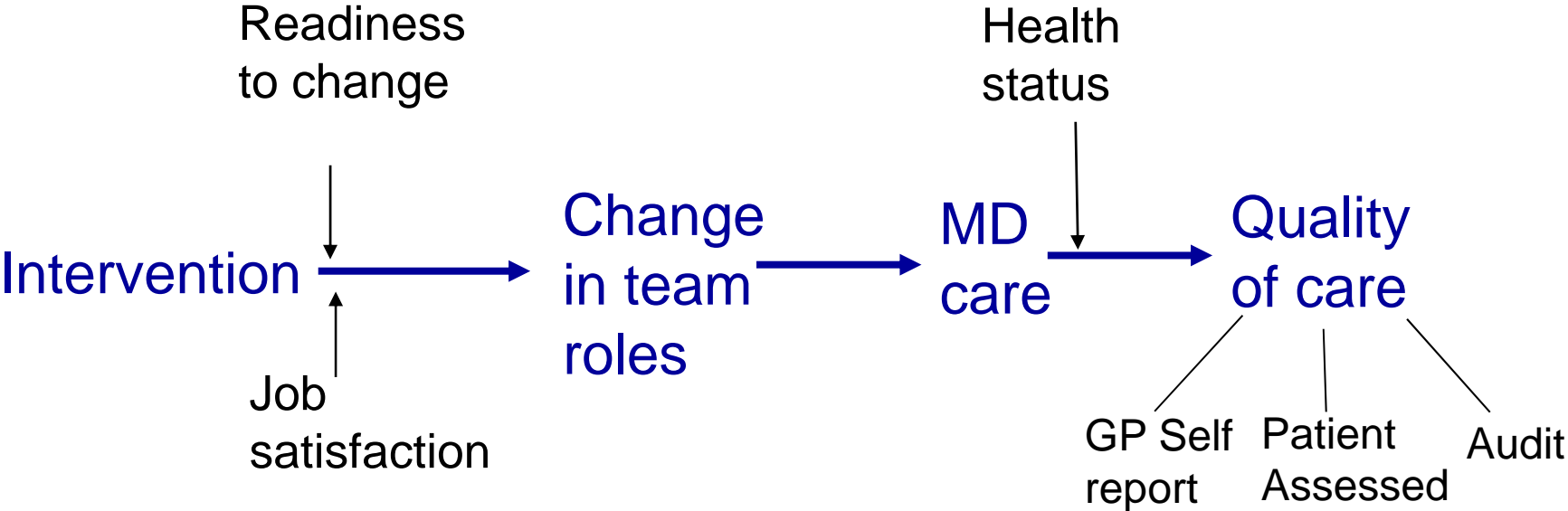
- Team roles and teamwork within the practice?
- Clinical linkages and multidisciplinary linkages between the practice and other providers (allied health)?

2. What impact does facilitation and training have on quality of care as measured by:-

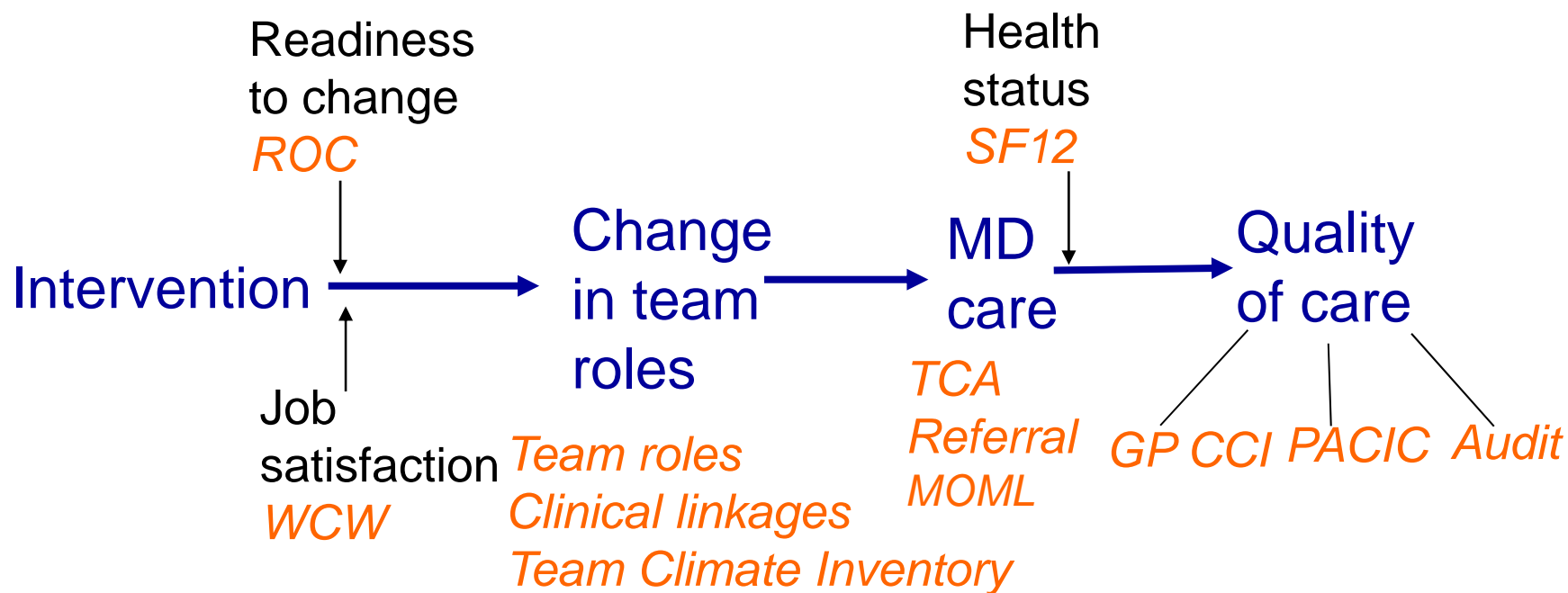
- Care planning
- Referral
- Patient assessed quality of chronic disease management
- Disease control (HbA1c, BP, Lipids)

3. Is this influenced by other factors (such as GP quality of care or health status of patients)?

Hypotheses

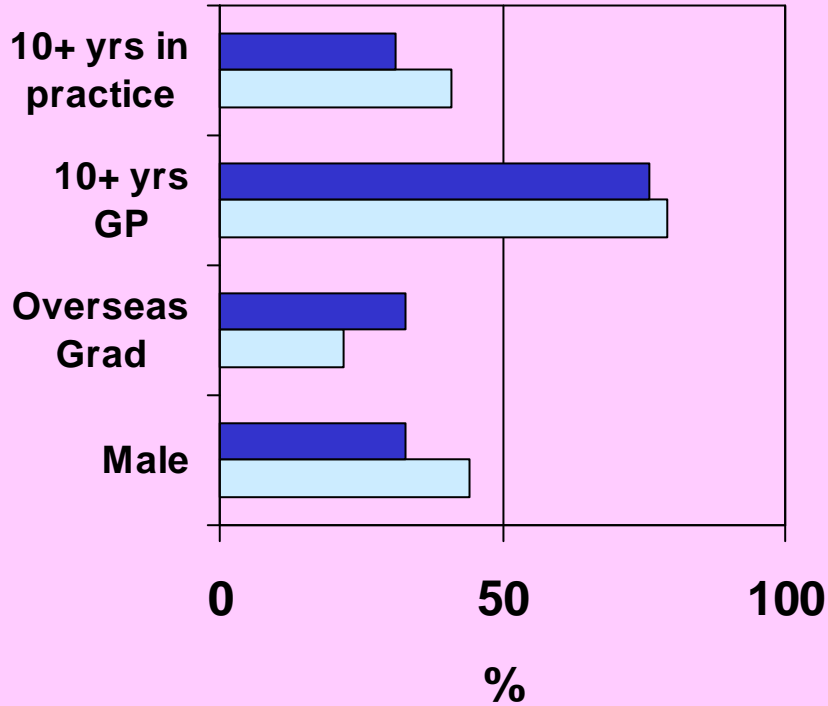


Impact Measures



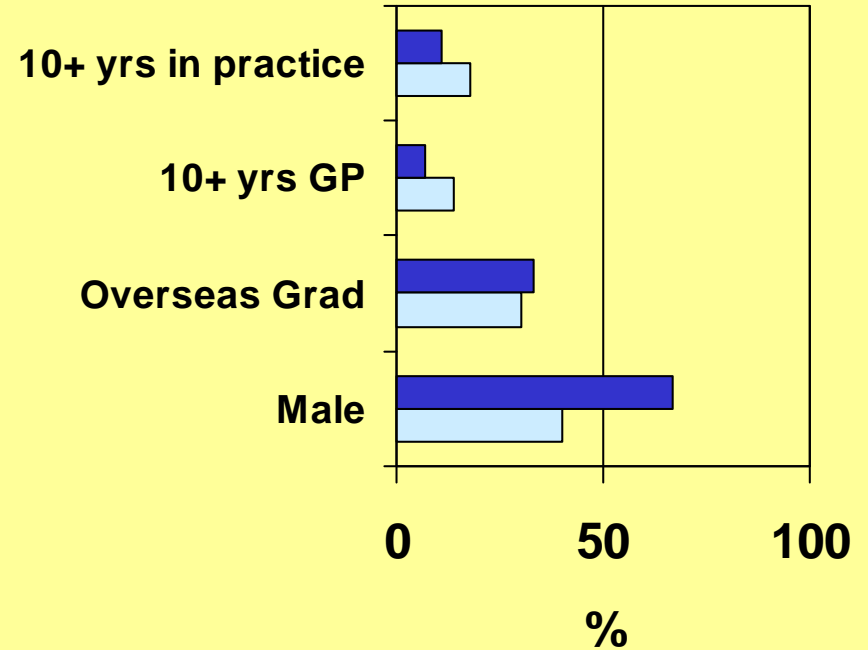
Practitioner characteristics

Teamwork



■ Intervention n=99 ■ Control n=94

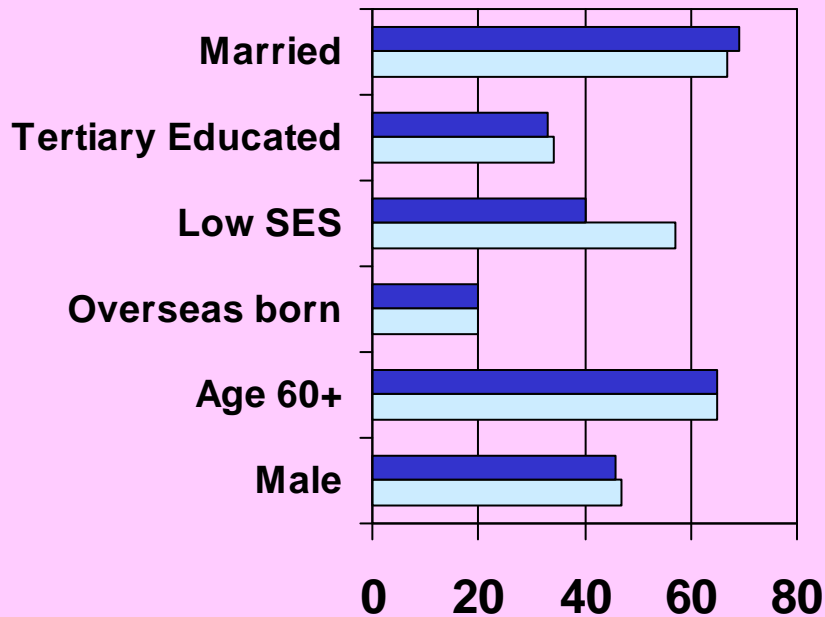
TeamLink



■ Late Intervention n=15
■ Early Intervention n=20

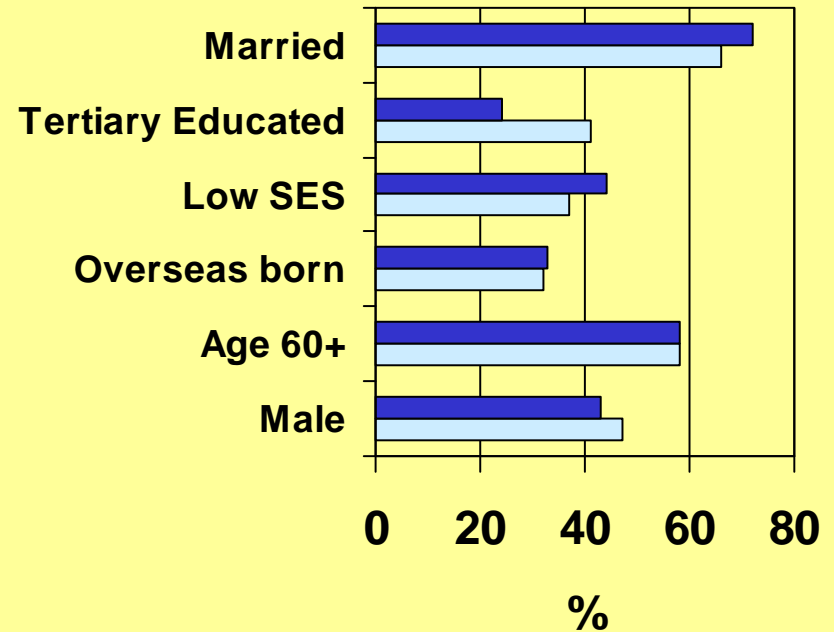
Patient characteristics

Teamwork



■ Control n = 836
■ Intervention n = 1093

TeamLink

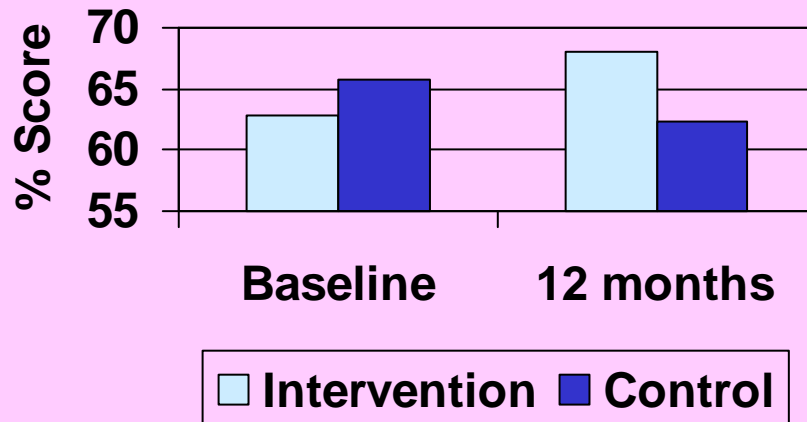


■ Late Intervention n=316
■ Early Intervention n=348

Change in Team Roles

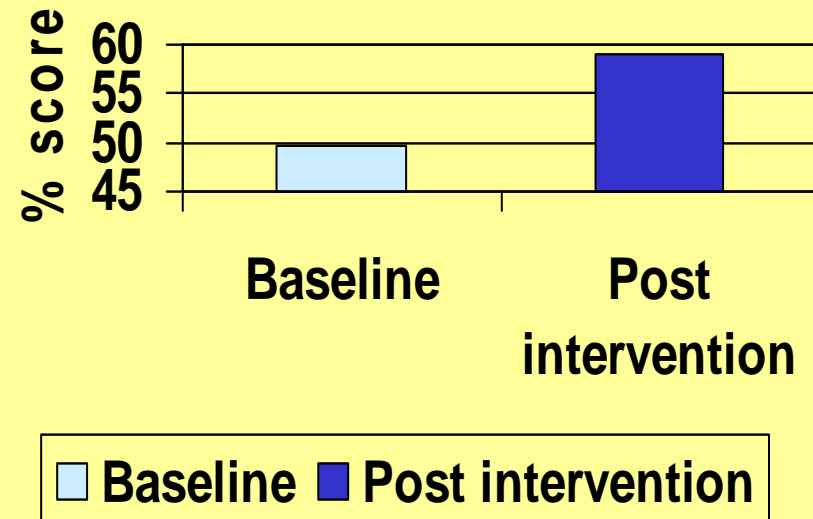
Teamwork

- No change in Clinical linkages, Team Climate or job satisfaction
- Team-roles – Intervention > Control



Team-Link

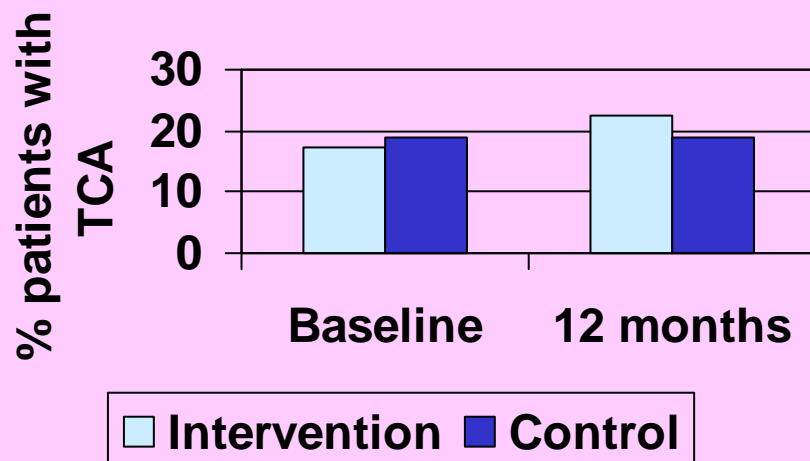
- No change in overall Clinical linkages but increase for shared care and decrease for community linkages
- Team-roles – Post intervention



Care planning and MD referral

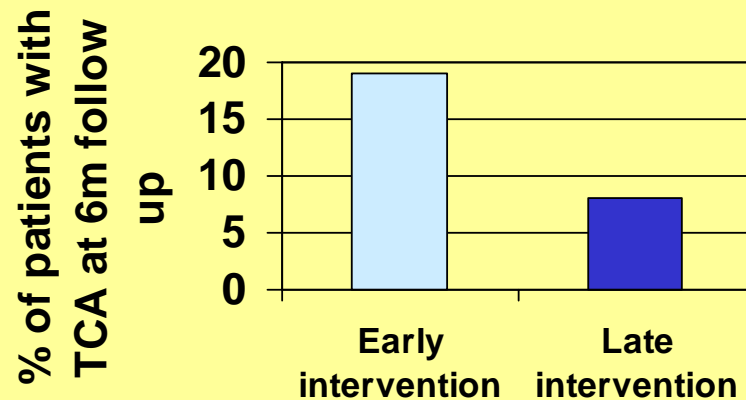
Teamwork

- ↑ proportion of patients with team care plans in previous 12 months (intervention not control)
- No change in the rate of referral



Team-Link

- Higher proportion of patients with completed a care plan in the previous 18 months in early than late intervention group
- No change in referral



- ↑ in satisfaction of GPs with multidisciplinary referral following intervention for patients with diabetes but less so for IHD

Patient Assessment of Chronic Illness (PACIC)

Teamwork

- Improved Total and factor 1 scores (shared decision making and self management) at 12 months in intervention vs control
- Factor 2 (planned care, referral and follow up) not associated with intervention
- Total and factor 1 scores related to older age.
- Total Score higher in patients with multiple condition and home ownership.
- Factor 2 score related to home ownership, retirement and multiple conditions

Teamlink

- No significant change in PACIC scores following intervention
- Total Scores were higher for
 - smaller practices vs larger
 - unemployed vs employed people
- Factor 2 scores were lower for patients aged between 45 – 59 yrs but higher for those with multiple conditions

Disease control (Audit)

Teamwork

- HbA1c improved for patients with diabetes in intervention but not control practices (7.25 to 7.11).
- No change in BP for patients with diabetes or IHD/Hypertension.
- Lipids improved in both groups of patients.

Team-link

- No difference in HbA1c, BP or lipids for patients in early or late intervention groups



GP self report quality of care

Teamwork

- ↑ in GP self reported quality of care for patients with diabetes and for patients with IHD/Hypertension in both intervention and control groups.
- No difference between groups at 12 months.

Team-link

- No significant change in GP self reported quality of care for patients with diabetes and for patients with IHD/Hypertension in both intervention and control groups.
- No difference between groups at 6 months.

Patient health status

Teamwork

- No significant change in SF12 physical or mental health scores and no difference between intervention or control groups at 12 months

Team-link

- Patient health status: No significant change in SF12 physical or mental health scores and no difference between intervention or control groups at 6 months



Conclusions: Team roles

- Practice facilitation and training enhance roles of non-GP staff (esp. practice manager and administrative staff roles but also practice nurses) in both Teamwork and Team-link studies.
- No changes to the overall team-climate of the practice or job satisfaction.
- At the end of the study, intervention practice staff were still ready to make further change, but not those in control practices.

Team care planning

- Team Care planning became more frequent following the intervention but not in control practices in both Teamwork and Team-link studies
- The frequency of referral to allied health providers did not change.
- In the Team-link study GP assessment of the quality of referral for patients with diabetes did improve after the intervention.

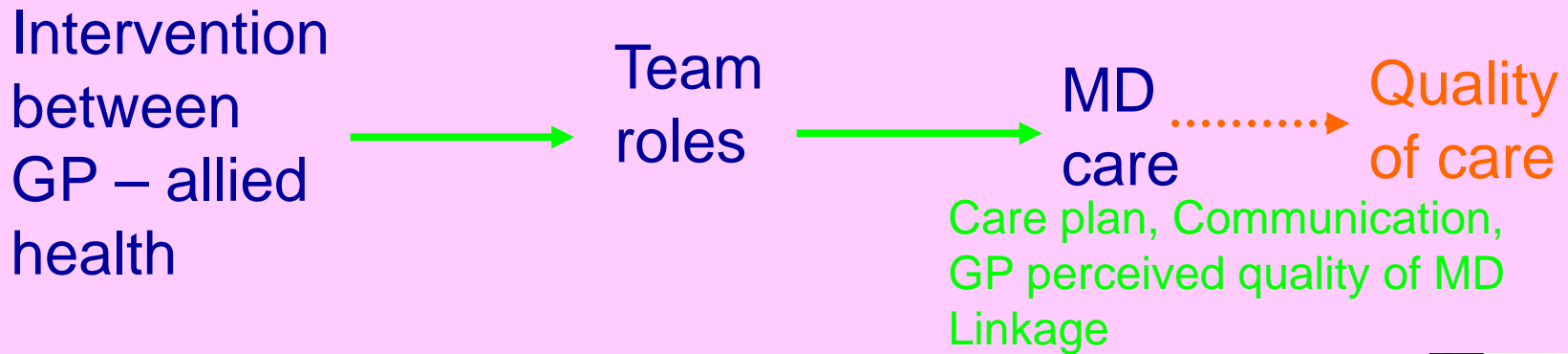
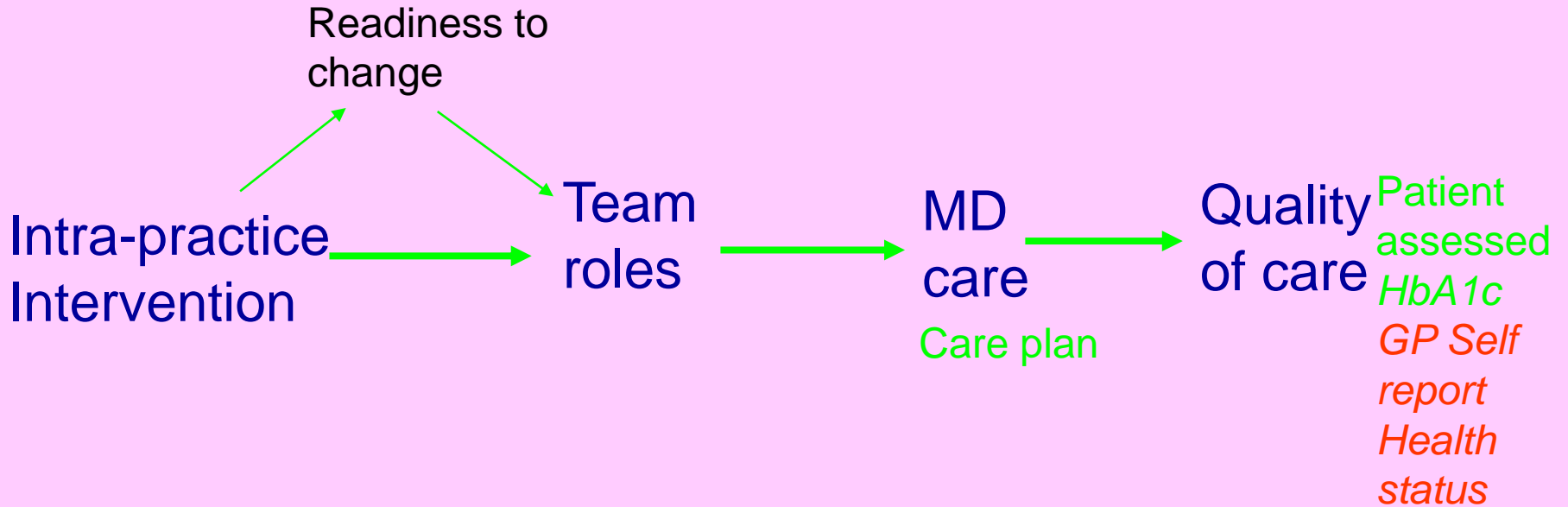




Quality of care

- Patient assessed quality of chronic illness care was higher in intervention than control practices at 12 months in the Teamwork study.
 - This was significant for total score and Factor 1 (patient centred care and self management) but not factor 2 (planned care).
- There was a trend for improved glycaemic control patients with diabetes in the Teamwork study in the intervention but not control practices.
- No other differences between intervention and control in BP or cholesterol were observed
- No changes in patient outcomes in Team-link study

Analysis



Some Implications

- Supports increased role of practice nurses and other non GP staff in the management of chronic disease and better linkages between general practice and allied health.
- Facilitating teamwork within the practice improves planned care & patient quality of care.
- Facilitating teamwork between the practice and allied health providers improves communication and planned care. However patient outcomes were not demonstrated possibility because:-
 - The intensity of intervention may not have been sufficient
 - the team-link intervention was for only 6 months.
 - Referral to other services did not change (in either study) suggesting a need for improved accessibility and a more effective network

Some Implications

- Both teamwork within the practice and between the practice and other providers outside require a structured program of facilitation
- This is an appropriate role for Divisions but it is additional to current education and practice support activities and will require some effort to ensure fidelity and intensity.
- Teamwork development is envisaged in PHC Taskforce and NHHRC interim reports. This is important but will not happen without facilitation.



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Questions?

