CONFERENCE ABSTRACT

Measuring the extent and drivers of integration within primary care teams

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Introduction: Given its core attributes as the gateway to the health system, the primary care sector is increasingly emphasized as a key player in the integration of care across providers and settings. Ontario's primary care sector has evolved considerably with the introduction of new inter-disciplinary models of primary care, including Family Health Teams FHTs and Community Health Centres CHC. However, our understanding of the specific features that enable integration within primary care teams is limited. This study sought to examine the extent and drivers of intra-organizational integration collaboration within team-based primary care models in Ontario specifically FHTs and CHCs.

Methods: Organizational features i.e., information technology [IT] capacities, information exchange, and rurality etc. and team characteristics size and provider attributes were assessed via the Organizational Profile Questionnaire, which was completed by the Executive Director for each CHC/FHT. Intra-organizational integration was measured using the Collaborative Practice Assessment Tool CPAT - a validated survey instrument, designed to measure collaboration within healthcare teams. All providers involved in care delivery were invited to complete the CPAT. A multi-variate linear regression analysis was conducted to explore the drivers of CPAT scores.

Results: A total of 44/73 CHCs 60% participation rate participated in this study, and 738 providers from a broad range of disciplines completed the CPAT. The response rate across CHCs was 45%, and 10% of respondents were male. Average age and length of employment were 43 years and 7 years respectively, and roster/panel size was approximately 4600 patients. The average CPAT score for CHCs was 47.21 SD = 1.97, Median: 47.25, Min: 43.74 and Max: 52.01. Regression analyses revealed that rurality, number of years in operation, roster/panel size, number of practice locations, IT capacity and information exchange were statistically significant predictors of CPAT scores. Data collection in FHTs is underway.

Discussion: The negative association between roster/panel size and CPAT score reflects qualitative insights around time constraints faced by providers in their effort to collaborate effectively within teams. Increasing the number of practice locations was associated with a lower CPAT score indicating challenges associated with dispersion, whereas rurality was associated with a higher CPAT score. A high level of IT capacity was associated with a higher

CPAT score - illustrating the role of technology in promoting integration efforts. In contrast, high levels of information exchange were associated with a lower CPAT score.

Conclusions: A narrow distribution of CPAT scores was observed for CHCs. Organizational features, specifically IT capacity, rurality and years in operation are important enablers of integration within CHCs.

Lessons learned: Team characteristics including size and provider attributes were not associated with CPAT scores. The inverse relationship between information exchange and CPAT score indicates possible gaps in perceptions of information exchange between executive leadership and individual providers.

Limitations: Since participation was optional there is potential for selection bias. Given the cross-sectional study design, changes in intra-organizational integration over time cannot be ascertained.

Suggestions for future research: Examining the association between integration within primary care teams and key system and patient-level outcomes are important next steps.