Rapid Scoping Review: Impact of primary care teams on clinician capacity to increase patient panel size

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BACKGROUND AND OBJECTIVE

Over 6.5 million adults in Canada do not have access to primary care, the front door to the healthcare system. Team-based primary care can theoretically expand clinician capacity to care for patients. However, it is unclear which health professionals, in what ratios and what roles can best grow clinician capacity.

Objective

We aim to summarize what is and is not known in the literature about **whether and how primary care teams improve clinician capacity to increase patient panel size**.

METHODS

- We are conducting a **rapid scoping review** as we anticipate heterogeneity and gaps in the literature
- The search will be conducted on MEDLINE and other bibliographical databases, we will search grey literature and key publications, and scan reference lists for forward citations
- Screening will be performed in Synthesis.SR
- We are looking at a broad range of outpatient groups and inter-professional, primary care clinicians working together in team-based collaborative settings to provide a range/basket of services to patients with relational and informational continuity

***Box 1**. Included Health Professionals*

Most responsible clinician = Family physicians, nurse practitioners, primary care pediatricians, internists, physician assistants

Other regulated health professionals = Registered nurses, registered practical nurses, psychologists, behavioural therapist, physiotherapists, pharmacists, dieticians, social workers, occupational therapists, midwives, respiratory therapists, paramedics, speech language pathology, chiropractors

***Table 1**. Inclusion/Exclusion criteria*

	Inclusion	Exclusion
Language	English	
Publication date	During or after 2000	
Location	High-income countries (World Bank)	
Design		Opinions, case notes, protocols, other non-methodological publications (i.e., no primary or secondary data)
Population	Primary care teams are comprised of two or more relevant*, different regulated health professionals working together on an ongoing basis to look after a shared set of patients (at least one is a most responsible clinician) (*See Box 1)	Non-medical roles and health professionals that are not regulated (e.g., administrative/clerical staff, medical office assistants, community health workers, Indigenous practitioners) Regulated health professionals uncommonly embedded in primary care practices.
	Teams have a core team (a "most responsible clinician" plus at least one other health professional) working together over time with shared records and patients (with no need for formal "referrals" or co-location.	Studies where the team-based care model is not consistent with the approach under consideration (e.g., physician-only teams, consultation-only teams without ongoing relationships)
Setting	Primary care is defined as outpatient care, first point of entry into health system, longitudinal/ongoing relationship between patient and clinician. Further services beyond primary care are coordinated with the external health system, and care is comprehensive (addressing different patient physical and mental health needs)	Episodic, non-longitudinal care (e.g., walk-in clinics, emergency/outpatient department, institution providing rehabilitation services, mental health and substance use services, palliative care services)
Outcomes	Studies that report data on the impact of inter-professional teams on most-responsible clinician capacity to see more patients (e.g., roster size, panel size, patient volumes, etc.)	

***Table 2**. Key data extraction elements*

Practice information Model of practice How clinicians are paid Integration training Culture of teamwork Team enablers Team governance Accountability Management structure IT/data support staff on team	**Secondary outcomes** Patient outcomes Provider experience Cost of care Patient morbidity and mortality How were each of the following measured and what was the outcome/data extracted?
Team interaction Interaction methods Frequency of interaction Information shared (Co)location information Shared client population	**Primary outcome** How is access/capacity/productivity measured? Impact on capacity Capacity increase attributed to…
Health professionals in the team Roles (e.g., family doctor, NP, psychiatrist) Ratios/number of team members per role Responsibilities of each team member Legal scope of practice of each team member	**Client/Panel information** Who is the population being served? Is the patient population shared? Panel complexity
Service delivery Basket of services Client encounter methods	**Equity considerations** Equity of changes observed (or sought) How the authors define equity, if at all

PRELIMINARY FINDINGS

Our search generated 14,653 hits. Our results will reveal studies assessing team impact on clinician capacity to serve more patients. We are extracting data on various factors including physician payment, team governance and culture of teamwork; types of health professionals, their roles and ratios; basket of services; patient population served and shared; clinician capacity change and measurement; and other outcomes including patient and clinician experiences, cost and equity.

CONCLUSIONS

Our analysis will identify literature that can guide implementation of team-based care in Ontario and other jurisdictions. Further research will be needed to understand teams' impact on clinician wellbeing, patient satisfaction and patient equity.

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