Canada's Primary Care: Models, Measurement and Innovation

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Scotland, May 2017

Overview

- Canadian Primary Care Models

- Performance Measurement

- A Sampling of Research and Innovation in Primary Care

- Scotland – New Scotland

Canada

- 9,984,670 **km**^{2}

- 36 million people

- Multicultural/Indigenous

- 75% live within 100 miles from the US border

- Life Expectancy at Birth: 82 years (Inuit: 64M/73F)

- 1/6 over the age of 65 years

We Want An Integrated Primary Care System That Will ....

- Offer primary care services for a defined population
- Be patient, carer and family-focused
- Provide comprehensive services with inter-professional teams
- Link with health and social care sectors
- Be accountable for outcomes

Canadian Academy of Health Sciences, 2011

IHPME

Social Context – Work Within or Change ??

- Social and Physical Setting: Work Insecurity

- Culture and Socialization: A Good Start

- Socio-Economic Status

- Social Relationships, Social Isolation/Integration, Social Support, Social Role Valorization

- Political and Policy Environment

10% of health care users

accounted for **77%** of costs
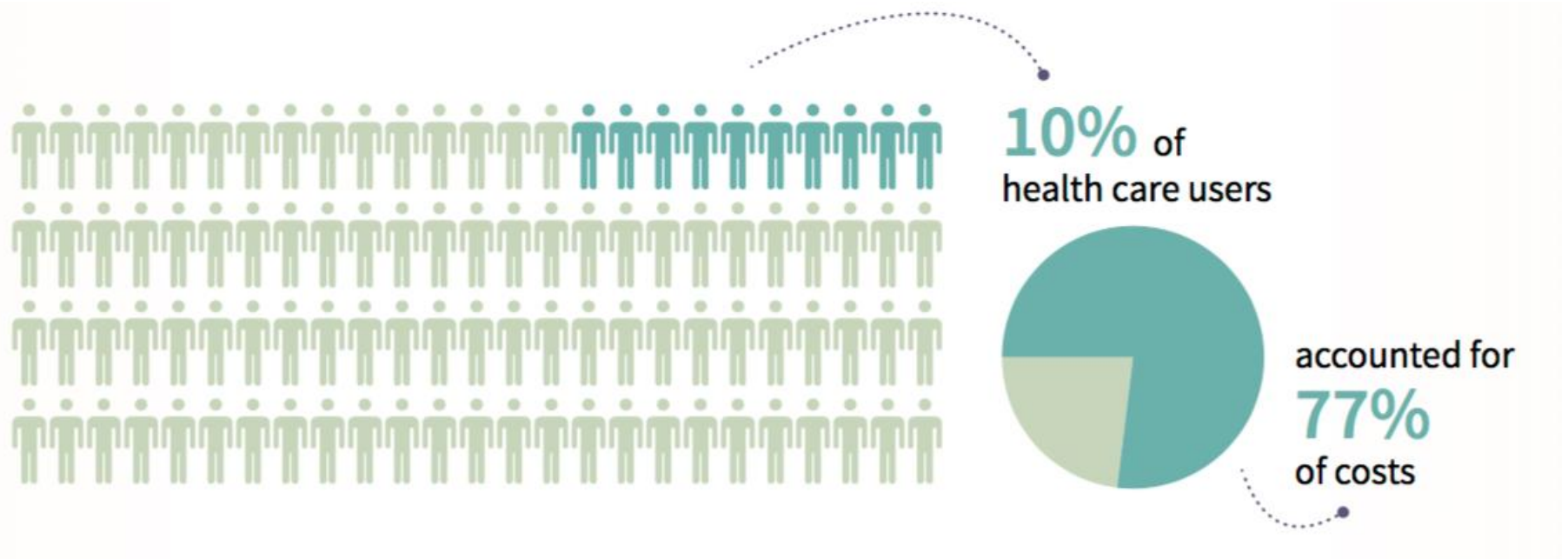
Source: Wodchis WP, Austin PC, Henry DA. A 3-year study of high-cost users of health care. CMAJ 2016 Jan. 11 [Epub ahead of print]

Canadian Medicare:
Universal Health Care Insurance

- Health service delivery a provincial responsibility
  - 13 provincial/territorial health care insurance programs

- Federal government funds provinces through the ***Canada Health Transfer*** ($36 Billion – 2016-7 – per capita). Contributions have been decreasing over time.

Ontario, Canada
Population: 13.9 million
14 Health Regions

Local Health Integration Networks in Ontario

Southern Ontario

1. Erie St. Clair
2. South West
8. Central
9. Central East

Models of Primary Care –Ontario, Quebec, Nova Scotia

- ***Primary Care Models in Ontario and Key Reform Characteristics – 2002 to Present.***

Marchildon and Hutchison, Health Policy.120(2016) 732-738

- Family Medicine Groups and CSSS's – Quebec

Hutchison, Levesque et al., Milbank Q, 2011, 89(2) 356-8

- Collaborative Care Practices – Nova Scotia ..NSHealth.ca

Primary Care Models in Ontario - 2016

- Family Health Group (2003) – 2565- 20.5%
- Comprehensive Care Model (2005) - 377– 3.0%
- Family Health Network (2002) – 230- 1.8%
- Family Health Organization (2007) – 5033 – 40.2%
- Rural/ Northern Physician Group Agr.(2004) 98 – 0.8%
- Nurse Practitioner Led Clinic (2007) – 97
- Family Health Team (2005) – 2771 - 22.1%

Plus Specialty Clinics and Integrated Primary/Hospital/Rehab Models (Kaiser - Like??)
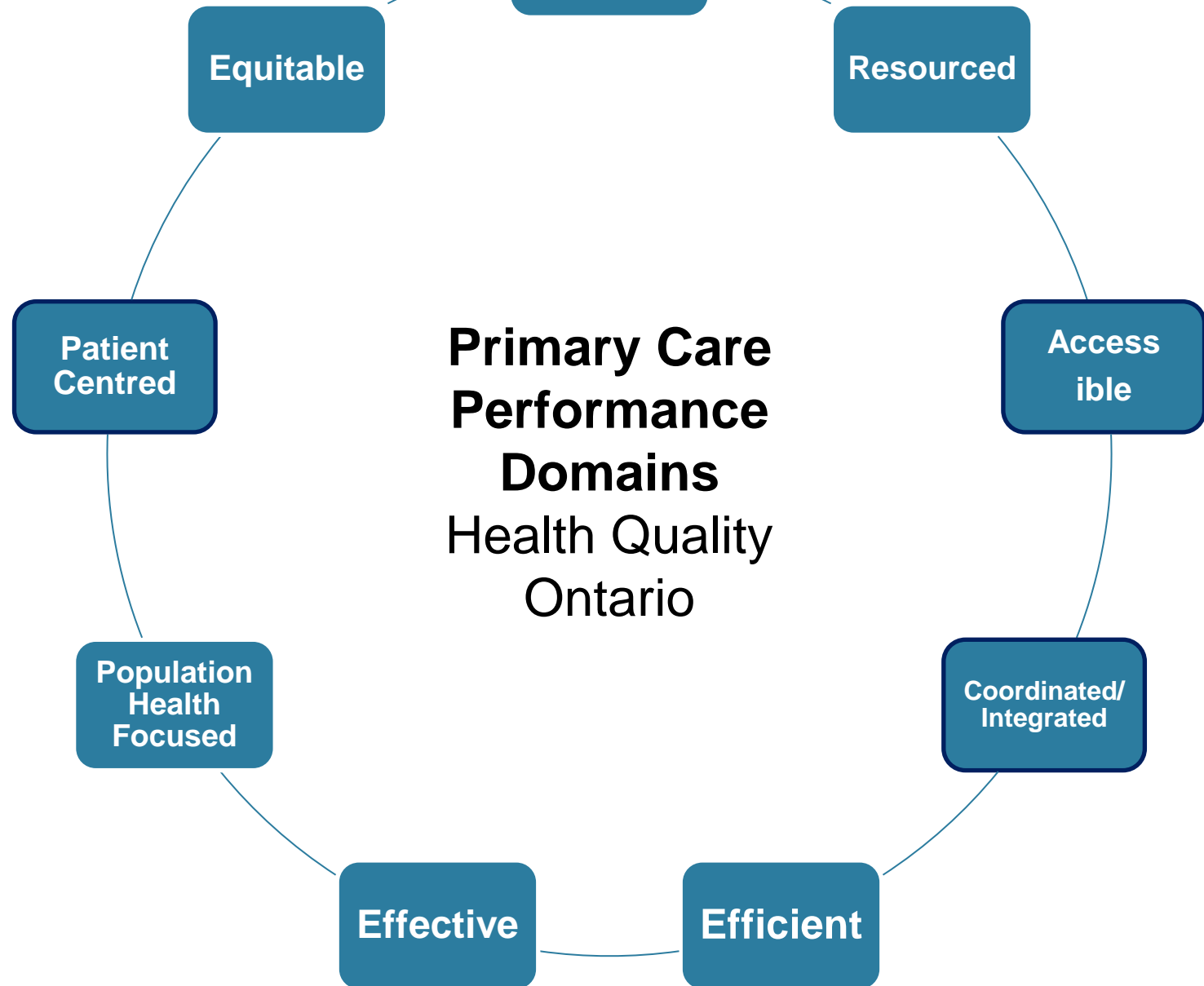
Patient Care Groups Proposal

- A New Model of Population Based Primary Care for Ontario, Price et al., 2015

Expert Advisory Committee on Strengthening Primary Care in Ontario

Challenges in Canada

- System Complexity
- Physician Engagement (Doctors Nova Scotia Report, April, 2017)
- Teamwork
- Requirements for Investment
- Equity
- Evidence-Informed Decision-Making – Performance Indicators
- Transformative Potential

Hutchison, Levesque et al., Primary Care in Canada, Milbank Quarterly, 2011 89(2) 256-288

Safe

Equitable

Resourced

Patient Centred

Primary Care Performance Domains
Health Quality Ontario

Access ible

Population Health Focused

Coordinated/ Integrated

Effective

Efficient

Access
and
Coordination

Source: Canadian Institute for Health Information. *How Canada Compares: Results From The Commonwealth Fund 2015 International Health Policy Survey of Primary Care Physicians*. Ottawa, ON: CIHI; 2016.
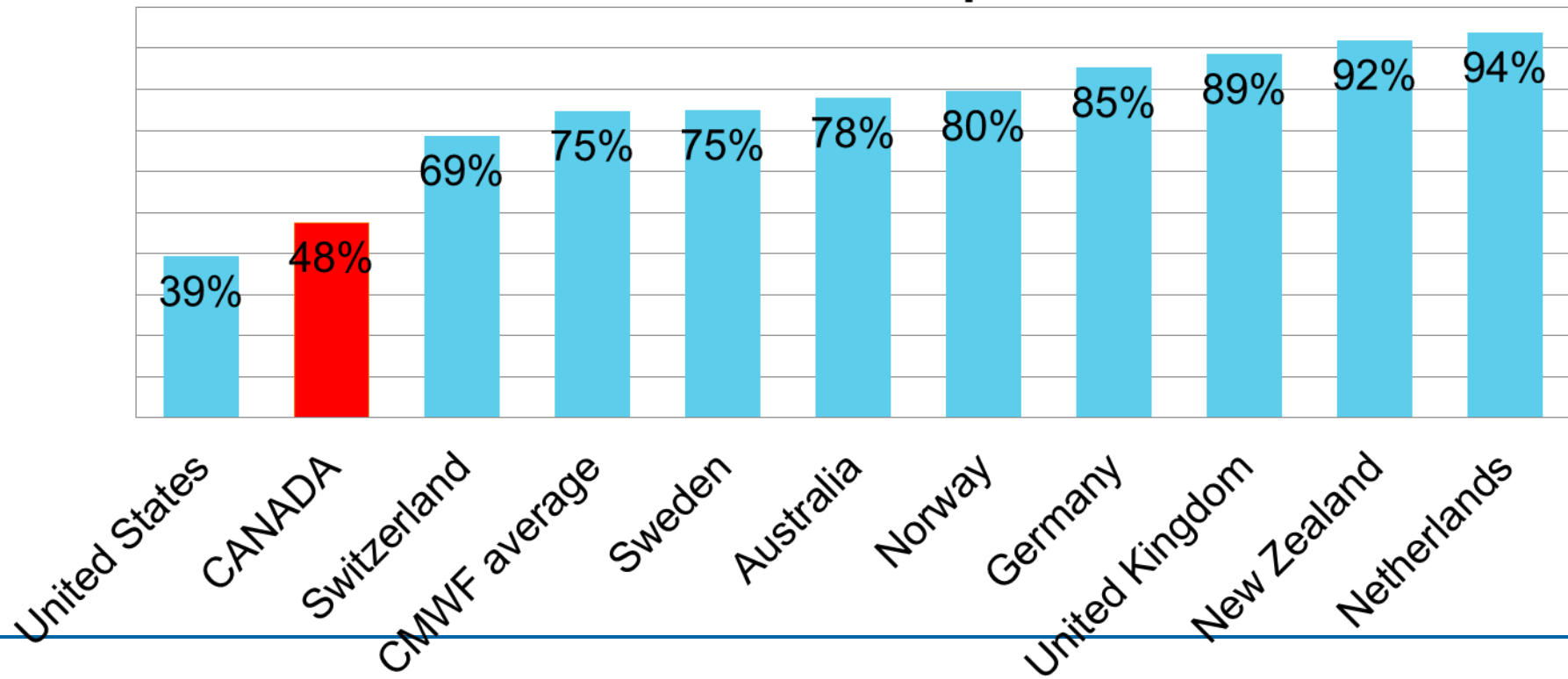
Access to Care
After Hours

48% — Practices where patients can see a doctor or nurse after hours without going to the ER.

How Does Canada Compare? 2015

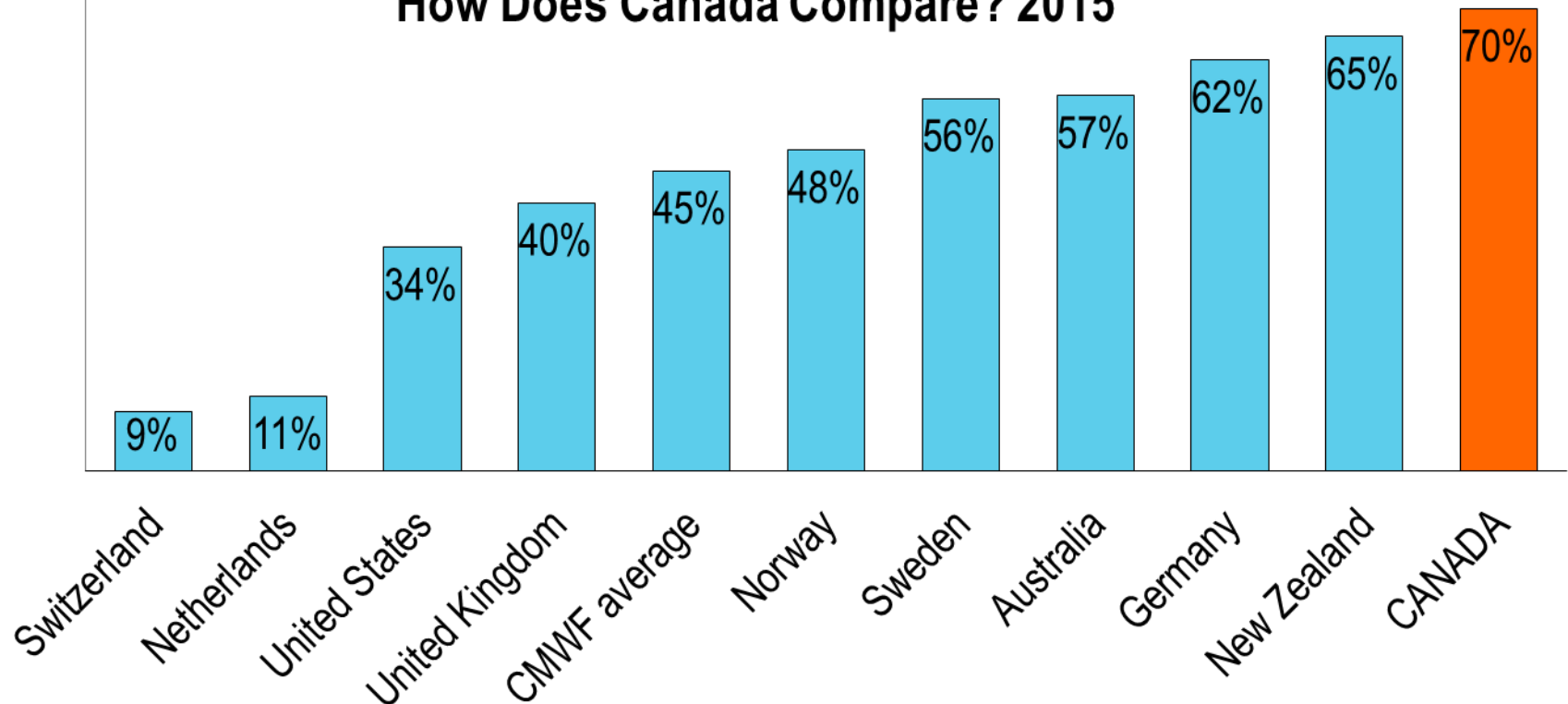| Country	Percentage
United States	39%
CANADA	48%
Switzerland	69%
CMWF average	75%
Sweden	75%
Australia	78%
Norway	80%
Germany	85%
United Kingdom	89%
New Zealand	92%
Netherlands	94%

Access to Care
Wait Times for Specialists

70% of Canadian primary care doctors thought their patients **often** experienced long wait times to see a specialist.

How Does Canada Compare? 2015

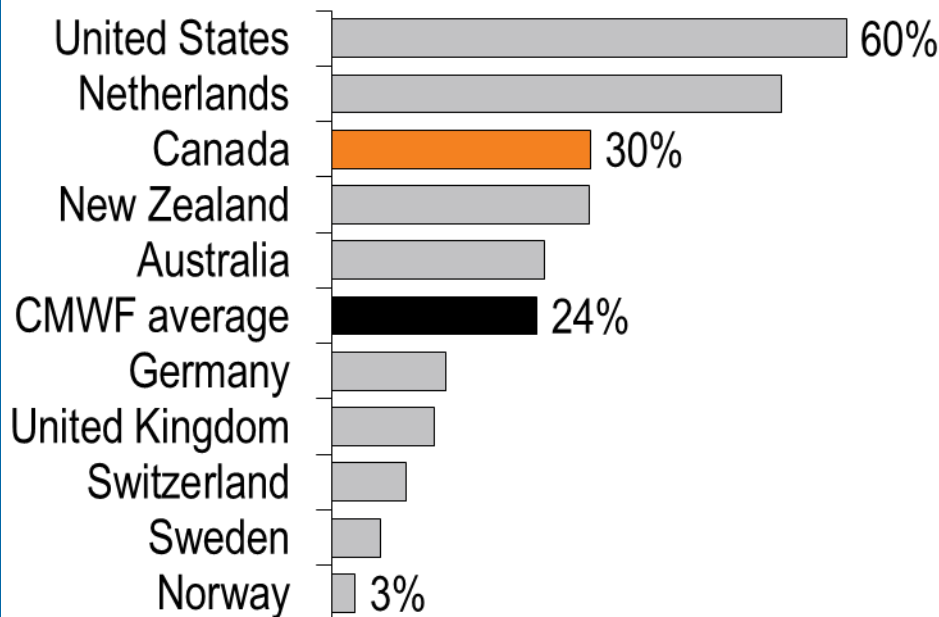| Country	Percentage
Switzerland	9%
Netherlands	11%
United States	34%
United Kingdom	40%
CMWF average	45%
Norway	48%
Sweden	56%
Australia	57%
Germany	62%
New Zealand	65%
CANADA	70%

Access to Care
Medication Cost Barriers

30% of Canadian primary care doctors thought their patients **often** experienced difficulty paying for medications or other out-of-pocket costs.

How does Canada compare (2015)?

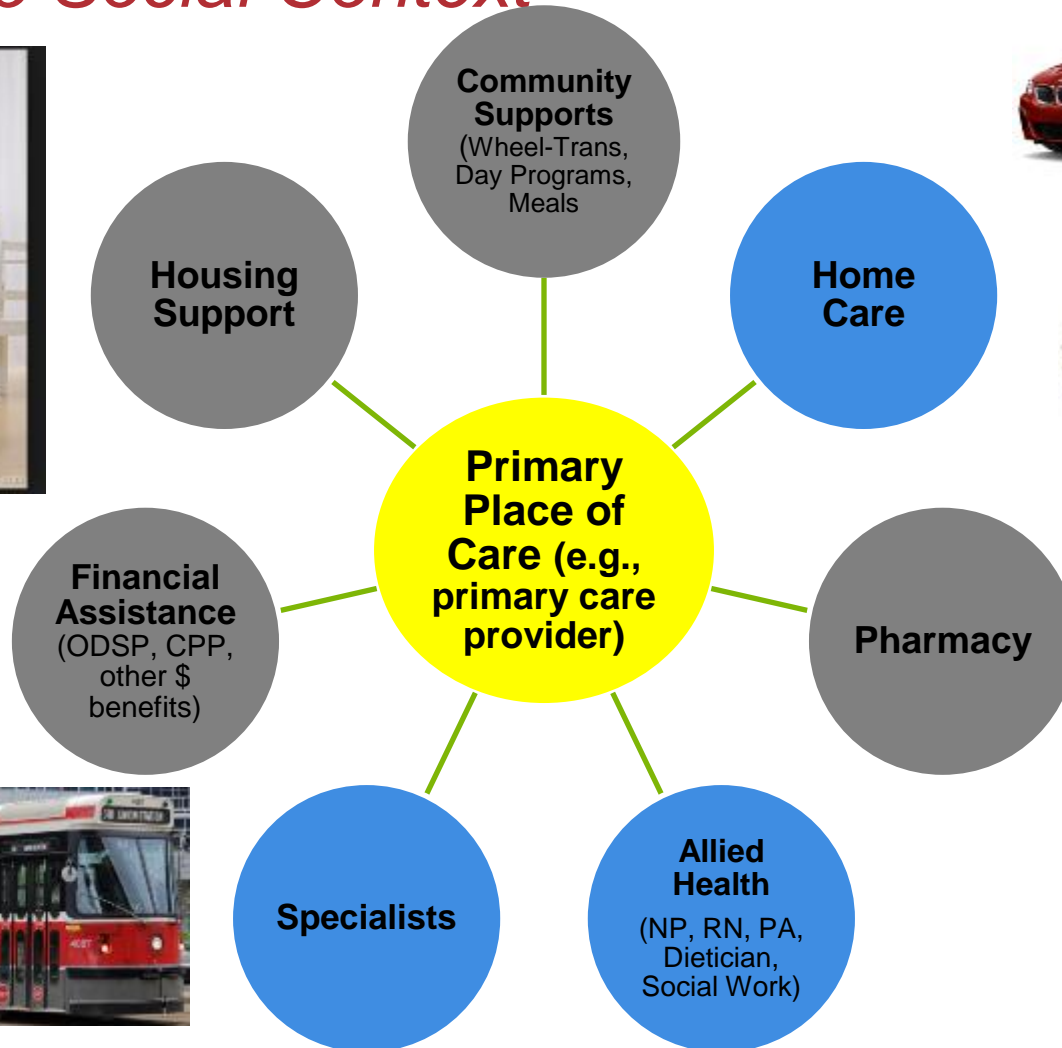| Country	%
United States	60%
Netherlands	
Canada	30%
New Zealand	
Australia	
CMWF average	24%
Germany	
United Kingdom	
Switzerland	
Sweden	
Norway	3%

In 2013, **1 in 12** Canadians reported that they did not fill a prescription for medicine or skipped doses of their medicine because of the cost.

Interpretation note: Above-average results are more desirable relative to the international average, while below-average results often indicate areas in need of improvement.
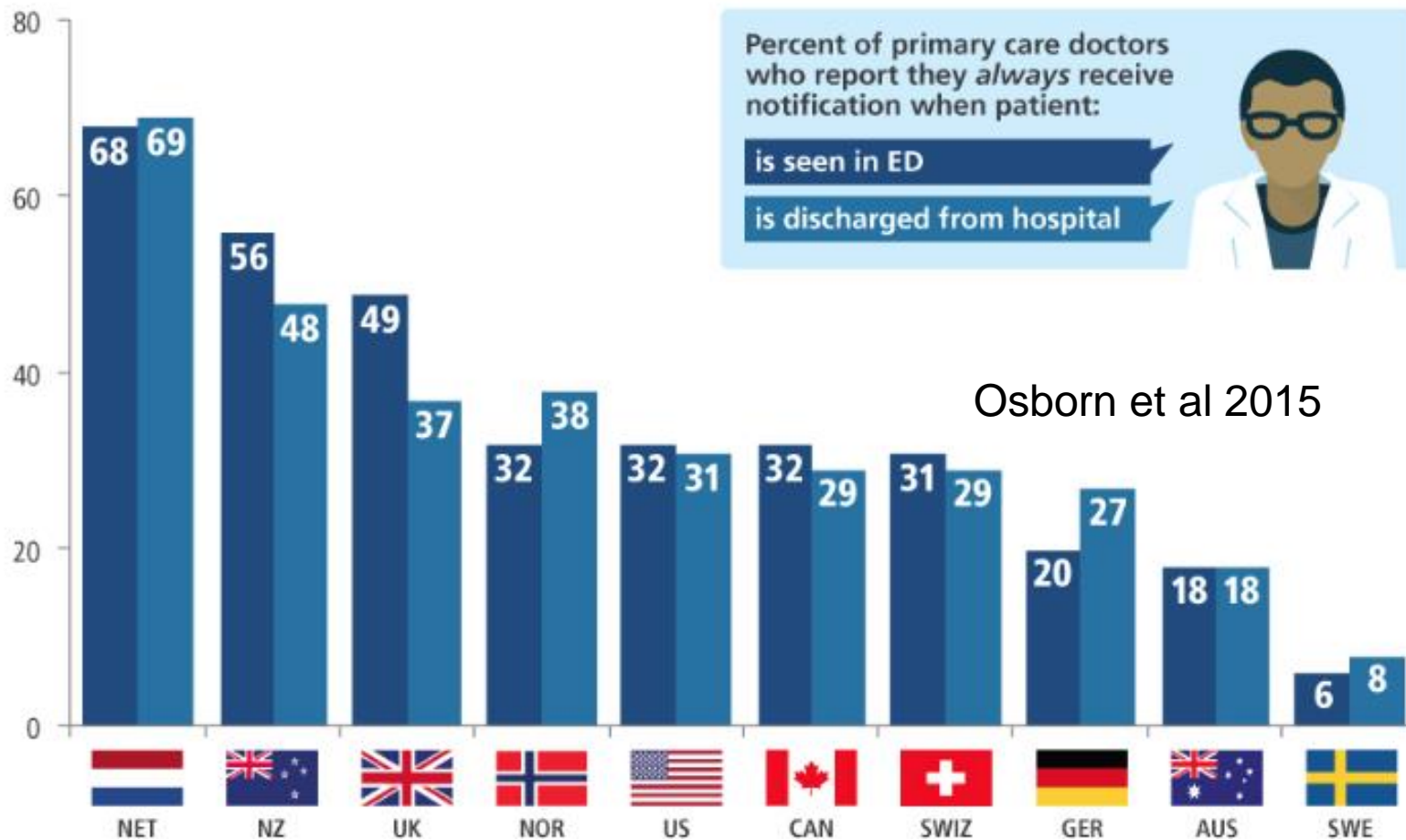
Access to Care
Related to Social Context

- Community Supports (Wheel-Trans, Day Programs, Meals)
- Housing Support
- Home Care
- Financial Assistance (ODSP, CPP, other $ benefits)
- Primary Place of Care (e.g., primary care provider)
- Pharmacy
- Specialists
- Allied Health (NP, RN, PA, Dietician, Social Work)

Coordination of Care

Communication between Emergency Room, Hospital and Doctor

Doctors in every country in a 10-nation survey reported that their practices struggled to coordinate care and communicate with other health providers, which is key to managing patients with complex care needs.
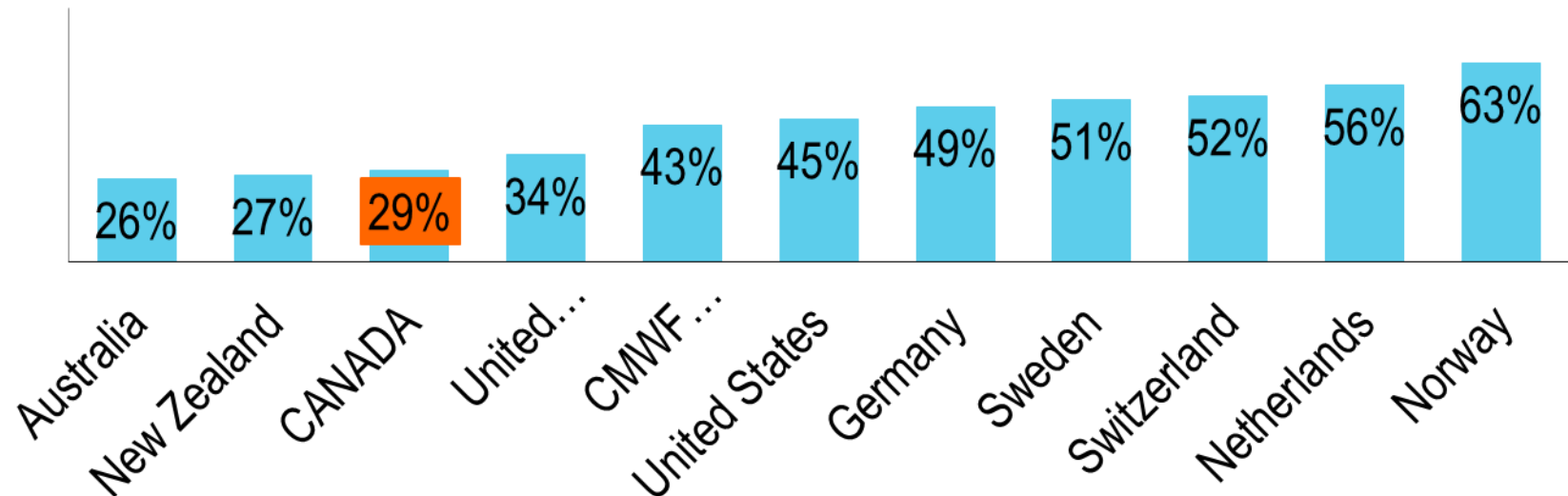
Percent of primary care doctors who report they *always* receive notification when patient:

is seen in ED

is discharged from hospital

Osborn et al 2015

Country	is seen in ED	is discharged from hospital
NET	68	69
NZ	56	48
UK	49	37
NOR	32	38
US	32	31
CAN	32	29
SWIZ	31	29
GER	20	27
AUS	18	18
SWE	6	8

Coordination of Care
with Homecare Services

% of physicians who regularly communicate with homecare staff about their patients who are receiving homecare services.
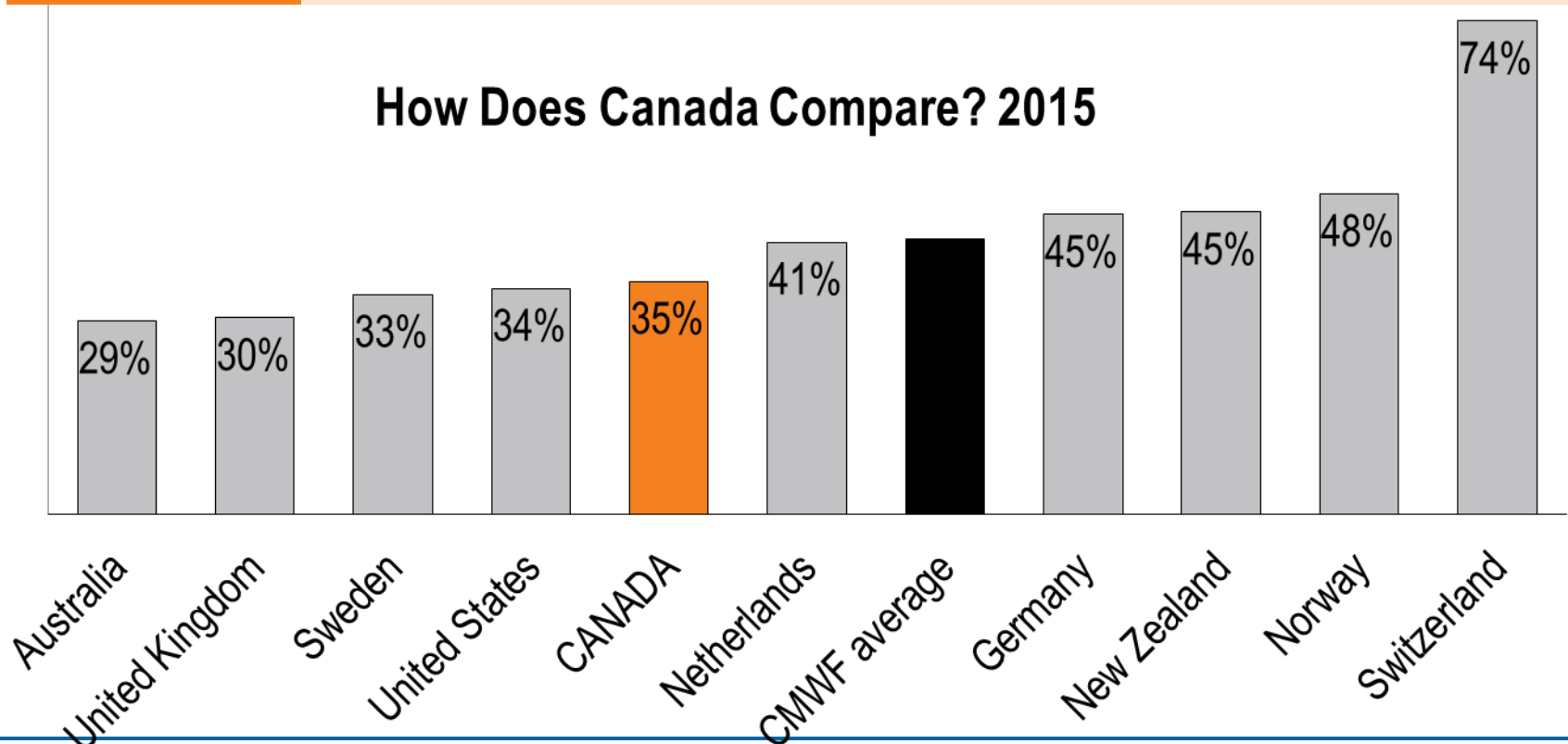
How Does Canada Compare? 2015

Australia	New Zealand	CANADA	United...	CMWF...	United States	Germany	Sweden	Switzerland	Netherlands	Norway
26%	27%	29%	34%	43%	45%	49%	51%	52%	56%	63%

Coordination of Care
with Social Care Services

35% of Canadian primary care doctors thought it was **easy or very easy** to coordinate their patient's care with social services or other community providers when needed (e.g., housing, meals, transportation).

How Does Canada Compare? 2015

Country	Percentage
Australia	29%
United Kingdom	30%
Sweden	33%
United States	34%
CANADA	35%
Netherlands	41%
CMWF average	
Germany	45%
New Zealand	45%
Norway	48%
Switzerland	74%

Understanding Patient and Family Experience

…particularly those with complex health and social care needs) and **identifying outcomes of importance.**

BMC Family Practice

RESEARCH ARTICLE   **Open Access**

A qualitative descriptive study on the alignment of care goals between older persons with multi-morbidities, their family physicians and informal caregivers

Kerry Kuluski[1,2*], Ashlinder Gill[2], Gayathri Naganathan[2], Ross Upshur[3,4,5], R Liisa Jaakkimainen[3,5,4] and Walter P Wodchis[2,5,6]

Abstract

Background: Goal setting is a recommended approach in clinical care that can help individuals with multi-morbidities and their caregivers manage chronic conditions. In this paper, the types of goals that were important for older persons with multi-morbidities were explored from the perspectives of patients, their caregivers and physicians. Comparisons of goals were made across each patient, caregiver and physician triad to determine alignment.

Methods: The study was a qualitative descriptive study facilitated through semi-structured one-on-one interviews. The study took place between May and October 2012 at a Family Health Team located in Ontario, Canada. The sample included 28 family medicine patients, their informal caregivers and family physicians. Socio-demographic data were analyzed via descriptive statistics in SPSS Version 17. Open ended questions pertaining to patient goals of care were analyzed thematically using NVivo9. Themes were derived on patient care goals for each of the participant groups (patients, caregivers and family physicians). Following this, alignment of goals across each of the triads was examined. Goal alignment was defined as concurrence on at least one goal by all three parties in a particular triad (i.e., patient, caregiver and family physician).

Results: Just over half of the patients were male (56%); they had an average age of 82.3 years and 4.61 health conditions. Most of the caregivers were female (82%); and 61% were a spouse of the care recipient. At the aggregate level, common goals expressed among patients, caregivers and family physicians were the maintenance of functional independence of patients and the management of their symptoms or functional challenges. Despite these common goals at the aggregate level, little alignment of goals was found when looking across patient-caregiver and physician triads. Lack of alignment tended to occur when patients had unstable or declining functional or cognitive health; when safety threats were noted; and when enhanced care services were required.

Conclusions: The data suggest that goal divergence tends to occur when patients are less medically stable. While goal divergence may be expected due to the different roles and responsibilities of each of the players involved, these perspectives should be illuminated when building care plans. Further research is required to observe the extent to which goal setting occurs in family practice as well as how it can be embedded as a standard of practice.

Keywords: Family practice, Multi-morbidity, Goals
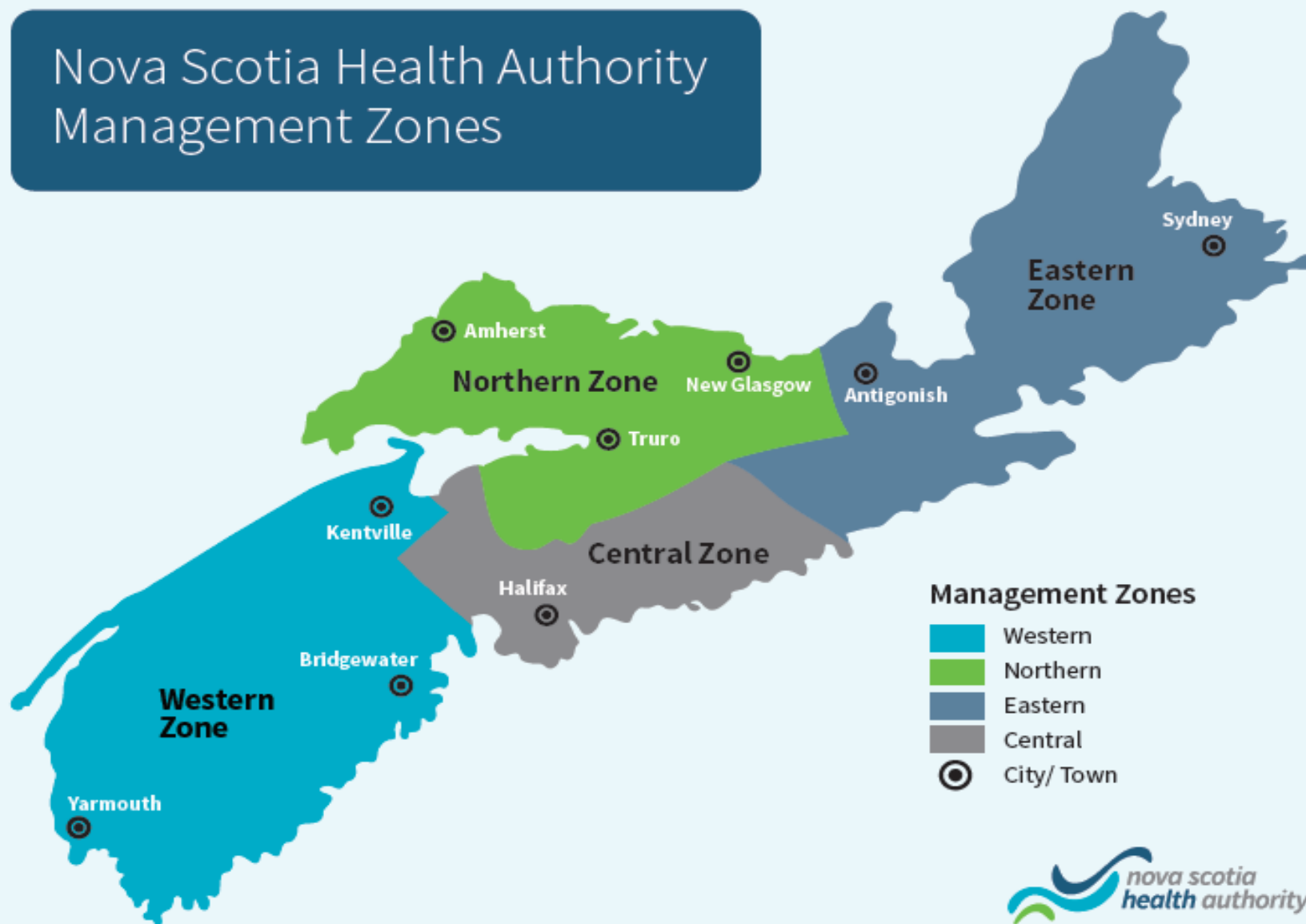
In Most Cases, Little Alignment

Patient	Caregiver	Physician
"Staying alive...to stay positive and upbeat..."	"...help with the memory loss, improving memory, he still enjoys social contacts..."	"So safety is a big concern for him. He lives with his elderly wife who's the primary caregiver. So she's at huge caregiver burnout risk there. And most recently, he's always had sort of outbursts of anger where he would, you know, hit things or throw things but not directed at her. But more recently she expressed some concern that, you know, he may actual direct it at her; so I guess my goal of care is to try to come up with a good long term care plan".

Canadian Innovations in Primary Care

- Access and Integration Experiments
- Patient Portals and Apps
- Paying Physicians for Complex Care
- Refugee Health Clinics
- Risk Assessment Tools
- Reviewing Practice Guidelines – Multi-morbidity

INTEGRATED CHRONIC CARE SERVICE – Nova Scotia

Functions

Community responsiveness and outreach: engagement, community development, priority populations

ICCS is provincial service

Wellness Promotion, Chronic Disease Prevention & Risk Factor Management

Primary Care Delivery Across the Lifespan

Integrated Chronic Disease Management Programs and Services

Research, surveillance, knowledge sharing, and evaluation through a Population Health* approach and in partnership with Public Health and others
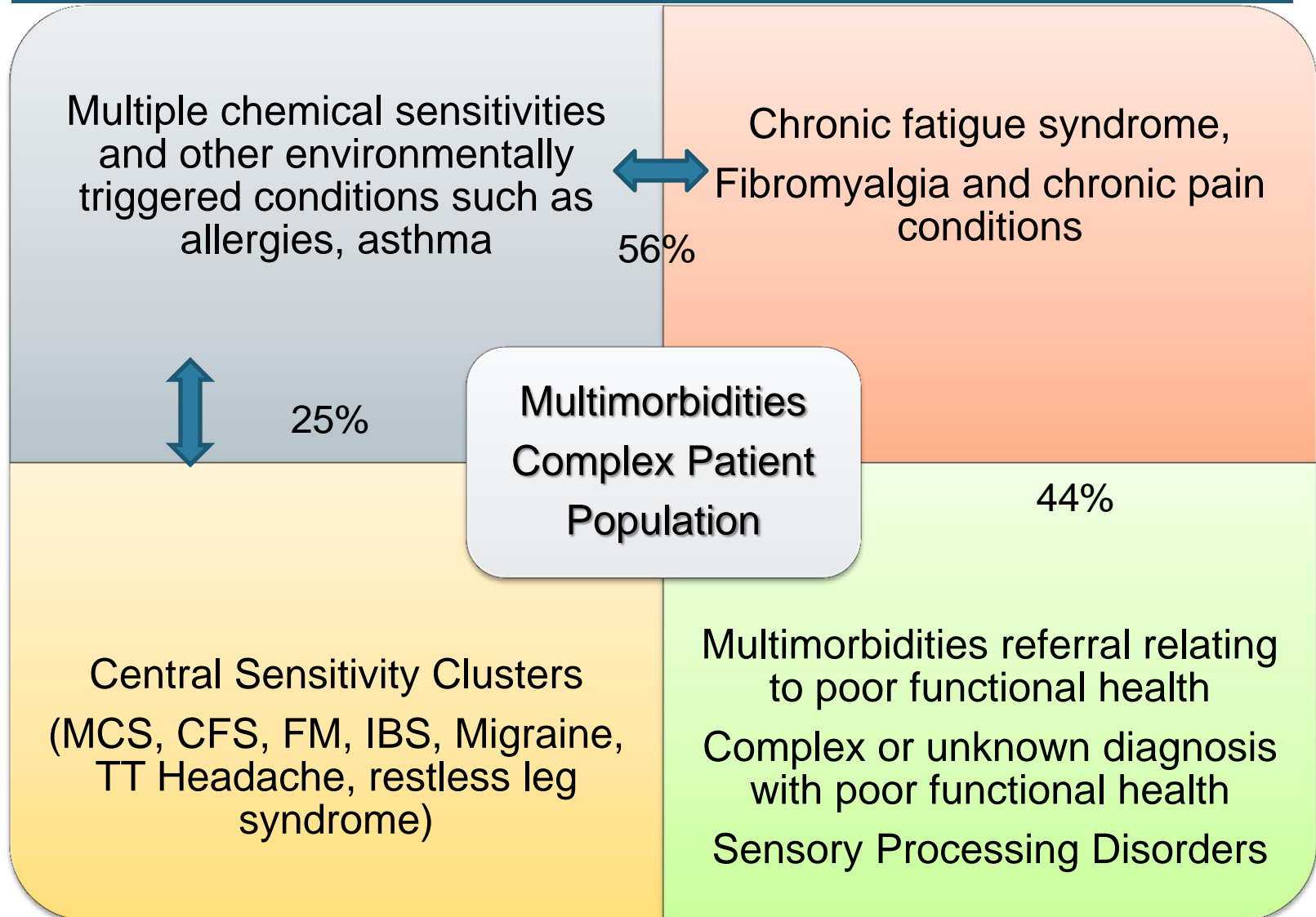
Enablers

| Leadership & Governance | Economic Conditions | Workforce | Engagement Platform | Quality, Safety, & Risk | Infrastructure | Accountability | Culture |

Functions and Enablers for the Nova Scotia Primary Health Care System

nova scotia health authority

Integrated Chronic Care Service

Service under Primary Health Care, provincial health authority

- Caring for patients with complex chronic conditions, multi-morbidities, unknown diagnosis and other complexities

- Team-based approach
  - Care team includes physician, nurse practitioner, care coordinators (OT), dietitian, nurses, psychotherapist

- Functional health management

PATIENTS OF ICCS

Multiple chemical sensitivities and other environmentally triggered conditions such as allergies, asthma

⟷

Chronic fatigue syndrome, Fibromyalgia and chronic pain conditions

56%

25%

Multimorbidities Complex Patient Population

44%

Central Sensitivity Clusters

(MCS, CFS, FM, IBS, Migraine, TT Headache, restless leg syndrome)

Multimorbidities referral relating to poor functional health

Complex or unknown diagnosis with poor functional health

Sensory Processing Disorders

Guiding models and frameworks for team-based care

Chronic Care Model

ICF Functional Health Model (WHO)

Person-centered care

Consensus Criteria and relevant CPGs

Whole-person care

Team work

Primary Health Care Competency Framework

Canadian Competency Framework for Interprofessional Collaboration

- New patient volumes
- Patient volumes discharge rates
- Wait times
- Referral rates
- Program component utilization
- Missed appointment, cancellations
- Phases of care

- Healthcare utilization
- Referrals
- ED utilization
- Disability and RTW
- Visits to PCPs

Process outcomes

Healthcare Costs

Health outcomes

Experience (patient and provider)

- COPM functional health, symptoms questionnaire
- Stanford
- SF-12
- Treatment-specific outcomes

- PACIC
- Hopes and Needs
- Interviews & satisfaction
- Stanford self-efficacy
- Referring physician satisfaction

ICCS OUTCOMES
(quadruple aim approach)

A whole-person care model for complex populations includes five elements

1 Care coordinator

- Deals directly with the patient
- Functions as quarterback
- Strong PCP involvement
- Develops personalized care plans
- Integrates multidisciplinary teams

2 Multidisciplinary healthcare team

- Approach patient care as a team
- Seamless handoffs among care providers

Physical health:
- Primary care
- Dietitians & fitness
- Pharmacy
- Specialists
- Hospital
- Lab

Mental health:
- Behavioral health
- County systems

Long-term care:
- Long-term-care facilities (hospice, nursing home)

3 Care collaborators

- Nonmedical entities
- Personal care needs

- Community groups
- Family
- State agencies
- Accessibility remodelers
- Translator/interpreter
- Home aides
- Faith groups
- Transportation
- Furniture movers

4 Informatics

- Health risk assessment tool
- Remote patient monitoring, emergency signaling
- Stratification and predictive modeling
- Workflow and notifications
- Accessible patient information systems

5 Incentive structures

- Single accountable entity
- Organization level: preventive health, behavioral health, and long-term-care providers
- Individual level: care coordinators, care team

Scotland – New Scotland

Thank You!

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