Institute of Health Policy, Management & Evaluation
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# Canada's Primary Care: Models, Innovation and Research

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**Scotland, May 2017**

IHPME

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# 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

# 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.

# 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

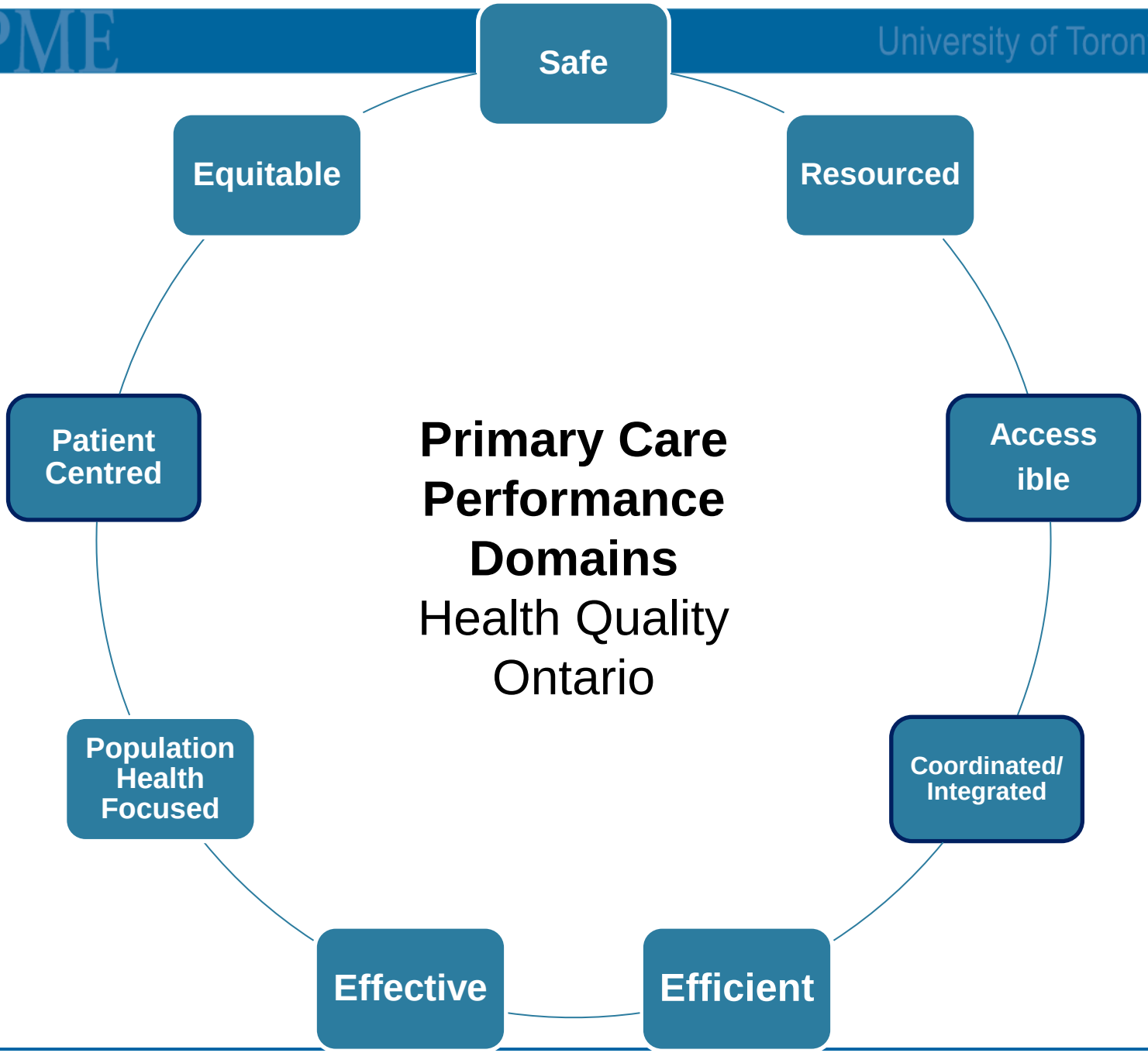
- A New Model of Population Based Primary Care for Ontario, Price et al., 2015

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

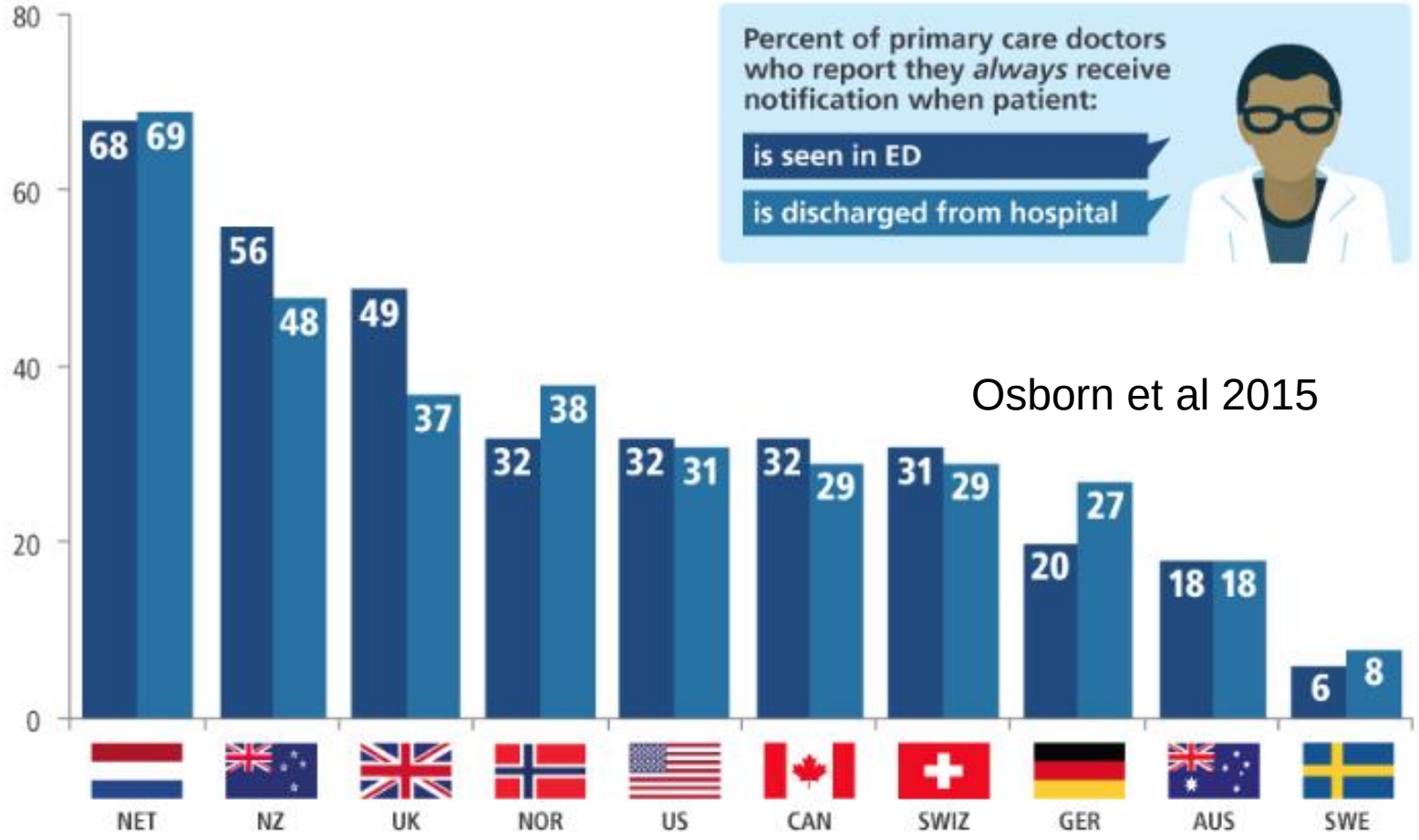
Hutchison, Levesque et al., Primary Care in Canada, Milbank Quarterly, 2011 89(2) 256-288


Safe
Resourced
Access ible
Coordinated/ Integrated
Efficient
Effective
Population Health Focused
Patient Centred
Equitable
Primary Care Performance Domains
Health Quality Ontario

# 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.

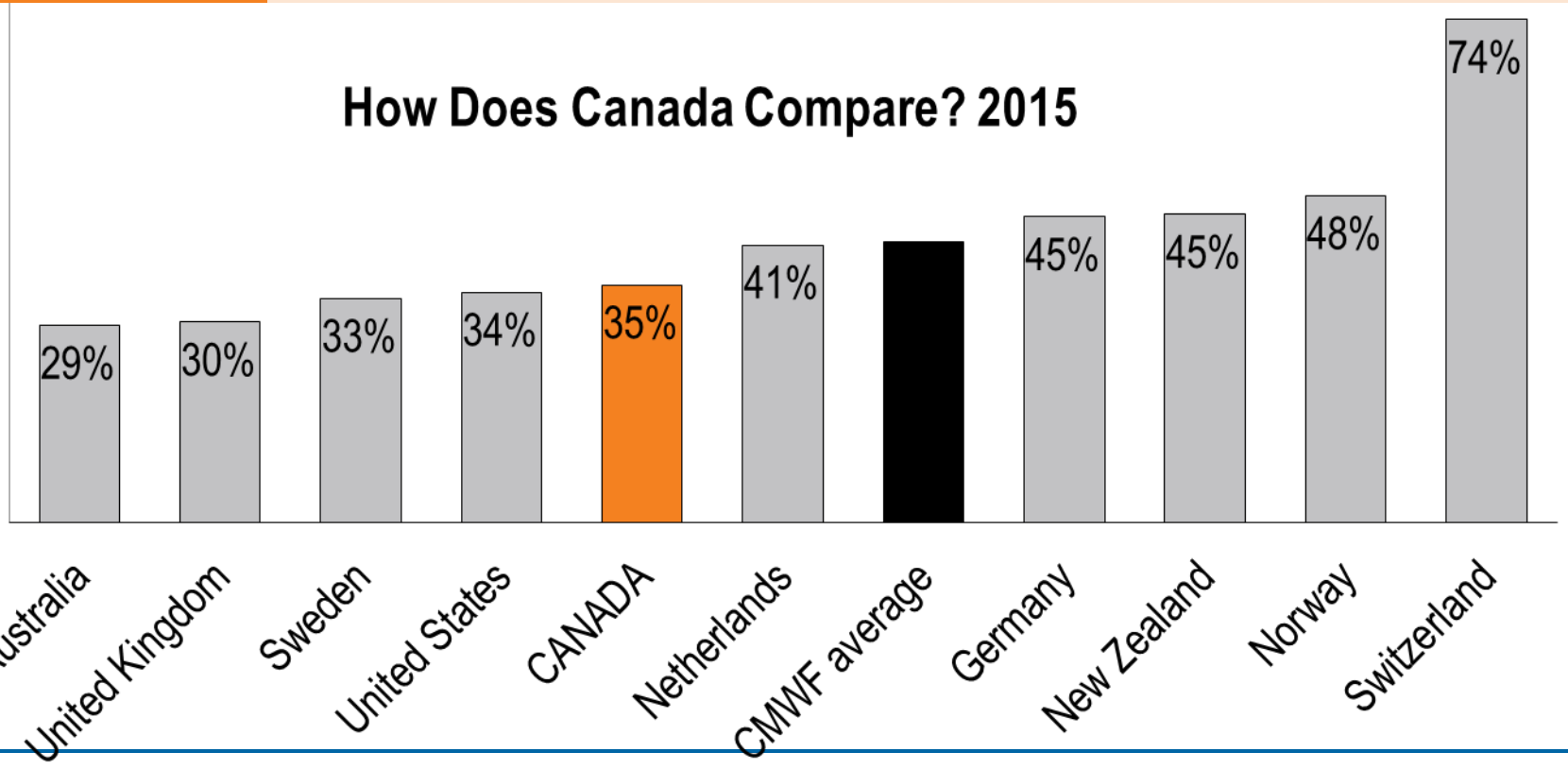



Osborn et al 2015

# Coordination of Care

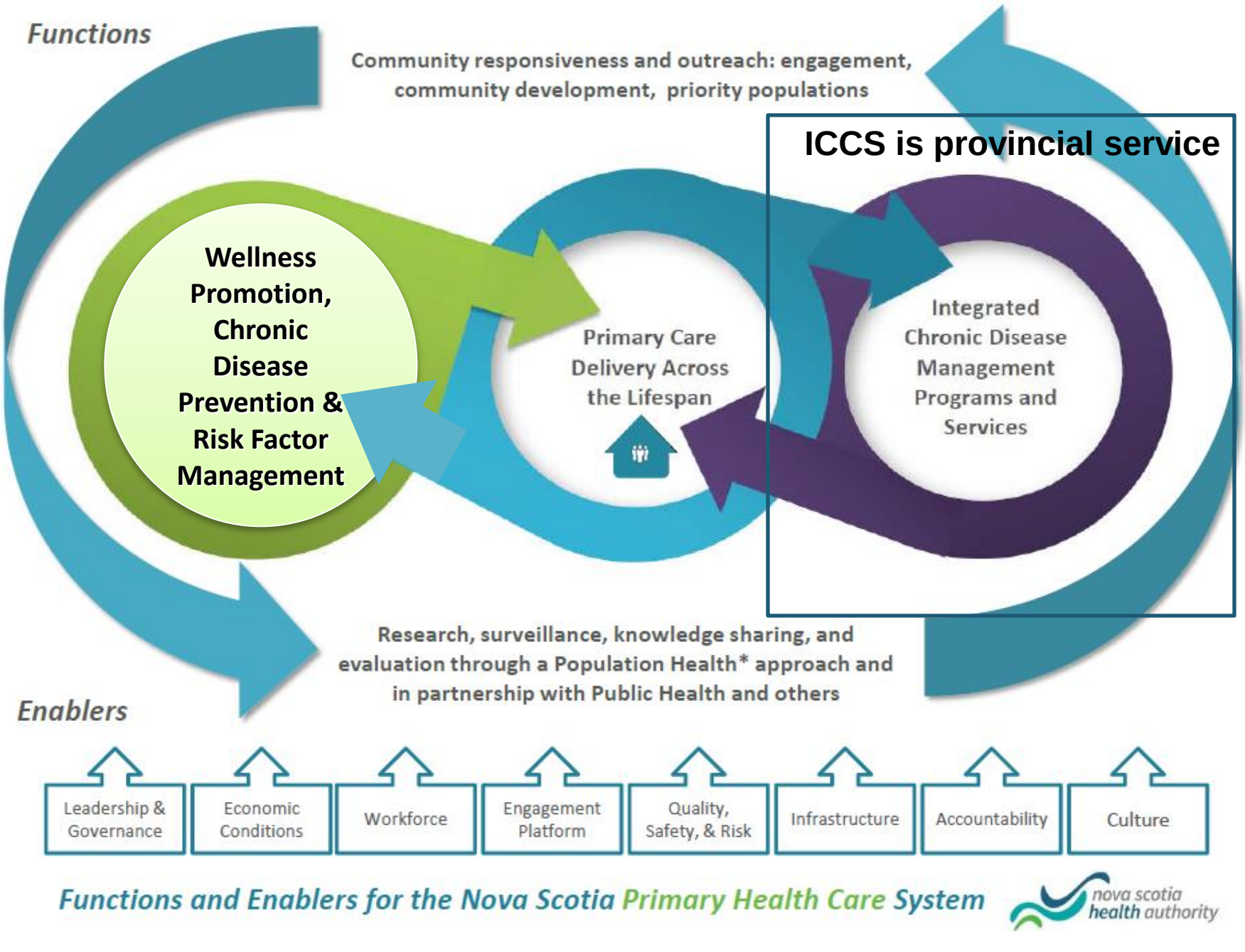
## *with Social Care Services*

**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).



# Canadian Innovations in Primary Care

- Access and Integration Experiments
- Patient Portals and Apps
- Integrated Chronic Care Services
- Paying Physicians for Complex Care
- Refugee and Mental Health Clinics
- Risk Assessment Tools




*Functions and Enablers for the Nova Scotia Primary Health Care System*

nova scotia health authority

# 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

Source: Strategy& analysis

BRIDGEPOINT active healthcare

# EXCITING OPPORTUNITY FOR INTEGRATED PRIMARY CARE RESEARCH

SPOR Innovations in Clinical Trials

Canadian Institutes of Health Research Competition, Review Panel, January, 2017

***Social context?!! Patient/Family Oriented Care?!! Health Systems***

# Scotland – New Scotland