Transformative Change in Canada’s Primary Care System: The Pace Quicksens

Our Health. Our Future
Igniting Change in Primary Health Care
Oct 2011
New Brunswick

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Co-Chair, Alberta AIM
Take the leap.... we will build our own wings on the way down.

Donald Berwick
Primary Care Renewal in Canada

Viewpoint

SPECIAL REPORT

New approach to primary medical care
Nine-point plan for a family practice service

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Since its creation almost 20 years ago, our national health care medicoare legislation: accessibility, universality, comprehensiveness, portability, and public administration? Is it effective and efficient? Is it affordable? Are the originally enunciated principles out of date? Do we need to add new ones?

This paper is about primary medical care: the level of care at which people initially come into contact with physicians and, in most cases, with the health care system. In a recent survey of Ontario residents, 98% of people claimed to have a family doctor. Family physicians have extensive training as generalists. Unlike the decades of
OUR PILLARS OF INTEGRATION

Integrated Service Delivery using Teams

- Governance through Co Management with the RHA
- Alternative Payment Model
- Integrated Electronic Record

Community Assessment and Shared Planning
“New Script, same old Play?”

- Saskatchewan Commission on Medicare. Caring for Medicare, Sustaining a Quality System (Fyke, Saskatoon: 2001)
- Quebec Study Commission on Health Services and Social Services. Emerging Solutions, Report and Recommendations (Quebec: 2000)
- Health Services Review Committee. Fredericton: 1999

Jeffery Simpson, Globe and Mail editorial, Jan 8, 2004

“New script, same old play?”

“Reform primary health care.”

(pick a model, any model)
“Discussions of innovations in primary care invariably take place in an evidentiary vacuum. Strong evidence is lacking to support the superiority of any one model of organizing, funding, and delivering primary care and of many suggested model components, including group practice, multidisciplinary practice and remuneration methods.”

2003 First Ministers Accord on Health Care Renewal

$800M invested in primary health care between 2000 and 2006 through the Primary Health Care Transition Fund (www.hc-sc.gc.ca)

“...With a goal toward “Timely and equitable access, a higher quality of care, a healthier population, a solid future for the Public Health system...”
Federal-Provincial Primary Care Initiative

Objectives

- Increase access to primary care.
- Provide coordinated ‘24/7’ access to appropriate primary care services.
- Increase the emphasis on health promotion, disease and injury prevention, complex patient care, and chronic disease management.
- Improve coordination and integration with secondary, tertiary and long-term care through linkages to specialty care.
- Facilitate the greater use of multidisciplinary teams to provide comprehensive care.
“The most obvious revelation here today is the huge provincial variation in approaches to primary care renewal initiatives across this country.”

Closing remarks, Dr Ruth Wilson
The Concern...

- While once Canada was seen in middle of the pack in primary care (Starfield et al, 2002), other countries of similar wealth and health systems have advanced and left us behind.
  - Health Quality Council of Canada 2007
  - 2008 Commonwealth Fund Survey

“Canada seems to have stalled in its commitment to strengthening primary care…In this regard, Canada is probably at least 10 years behind.”

★ Barbara Starfield, 2008
Is there a common vision developing around what we need to do to strengthen primary care in Canada?

If so, what should that look like?
What do we know works in Canada...

• Practices that provide comprehensive and coordinated quality primary health care confer the most benefit to their patients.

• Generally, such practices:
  – have a sound knowledge of their patient population, and of their community resources
  – have effective patient flow processes
  – use protocols and guidelines to support provision of evidence-based care
  – provide collaborative team-based care, whether co-located or not
  – use and share sophisticated electronic medical records that include clinical decision support, prompts, reminders, registries, etc.

What we Know ...

- **Strongest evidence** for primary care improvement exists for delivery system redesign within primary care.
  - Enhanced access through redesign of the scheduling
  - Enhanced quality of care through Interventions that reshape multidisciplinary team-based care

- **Strong evidence** for Self Management, if integrated into the ‘regular care’ provided within the trusted relationship of a medical home.

Kreindler, S. Lifting the Burden on Chronic Disease: Whats Worked, What Hasn’t. What Next. WRHA, May 2008
What we Know …

“The Medical Home”

• The greater the range of services provided by primary care practitioners, the lower the all-cause mortality, life expectancy, and overall costs for health services.
• those who had a primary care physician as their regular source of care had one third lower costs and were 19% less likely to die, even after controlling for several other predispositions to dying

Starfield B, Shi L. Policy relevant determinants of health: an international perspective. Health Policy. 2002;603:201–218
What we Know ...

Is there an advantage of a medical home—whether it be a particular person, or a particular place—over a combination of different sources of care?

- Identification of a particular practitioner provides better services than mere identification of a particular place.
- A family physician with a continuous care relationship to a defined patient population was the characteristic consistently related to these better outcomes.

What we Know …

Patient-Physician “Connectedness” & Quality of Care

– 13 Academic community and hospital based family practices (155,590 patients)
– “Physician connected pts” were significantly more likely to receive guideline level care than “practice connected pts”
  • Mammograms: 78.1% vs 65.9%
  • HgA1C: 90.3% vs 74.9%

What we Know ...

Patient-Physician “Connectedness” & Cost of Care

– “The more patients go the same practice, the lower the overall cost to the health care system.”
– “Attachment to a practice” was the best predictor of lower hospital costs, and was more significant than other variables, such as age.

A VISION FOR CANADA

Family Practice

The Patient’s Medical Home

The College of Family Physicians of Canada

Sept 2011

http://www.cfpc.ca
A VISION FOR CANADA

Family Practice

The Patient’s Medical Home

http://www.cfpc.ca
The Patient’s Medical Home

The Patient’s Medical Home is the hub – or home-base – for the provision and coordination of all the health and medical services needed by each of its patients.

This vision outlines that every person in Canada should have access to a family practice/primary care setting that serves as their medical home.

Patients’ Medical Homes will produce the best possible health outcomes for the patients, the practice populations, and the communities they serve.

Patient Medical Home models are emerging across Canada:

The Patient’s Medical Home

- **Personal Family Physician and Teams**: Every Canadian with a personal family physician and access to an inter-professional team
- **Timely Access**: reduced waits for primary care with teams and same-day scheduling
- **Coordinated, Comprehensive Care**: full basket of family practice services coordinated with other health and medical services needed outside the practice
- **Continuity of Care**: access to same care provider over time is critical factor in producing best health outcomes*
- **Prevention and Health Promotion**: increased focus on wellness and improving health outcomes for individuals, communities and populations
- **Chronic disease management**

Sources:
The Patient’s Medical Home

• Putting the focus on patients – enhanced participation in and access to care, better prevention and wellness, better health outcomes
• Every Canadian with a personal family doctor and access to a personal health care team
• Each member of the medical home contributes her/his skills and strengths
• Each PMH must have support to ensure EMRs/EHRs
• Must have sustained system support for comprehensive primary care/family practice, health promotion and wellness
• The current Health Accord, which expires in 2014, must be extended for at least another 10 years
Family Practice Medical Home Models in Canada

- British Columbia: Integrated Health Networks (IHN)
- Alberta: Primary Care Networks (PCN)
- Saskatchewan: Primary Health Networks/Teams
- Manitoba: Physician Integrated Networks (PIN)
- Ontario: Family Health Teams (FHT)
- Quebec: Groupe de medicine de famille
- New Brunswick: Family Health Centres
- Nova Scotia: Primary Care Teams
- PEI: Family Health Care Teams
- NFLD and Labrador: Primary Care Teams
- NWT/Yukon/Nunavut
A Very Old Adage:

What is it our patients value most?

– Accessibility
– Amiability
– Ability

IN THAT ORDER!
What do our patients say they value?

The single most important issue for Canadians is poor **access** to health services. 79% said the health system in urgently in need of fundamental change. (Health Quality Council of Canada, Dec 2007)

Delay in seeing a doctor and getting treatment is the longest among the seven developed countries. (2008 Commonwealth Fund Survey)

*When the Clock Starts Ticking*, CFPC, 2006
So what happens when patients can’t get in to see their physician?

Is it OK to wait?
Access to a Doctor When Sick

Base: Adults with any chronic condition

6+ days wait or never able to get appointment

Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.
ER Use Past 2 Years

Base: Adults with any chronic condition

Percent

Any ER use

Used ER for condition treatable by regular doctor, if available

Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.
Wait Time for Specialist Appointment

Base: Adults with any chronic condition who needed to see a specialist in past 2 years

<table>
<thead>
<tr>
<th>Percent</th>
<th>Less than 4 weeks</th>
<th>Two months or longer</th>
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<tbody>
<tr>
<td>US</td>
<td>74</td>
<td>10</td>
</tr>
<tr>
<td>NETH</td>
<td>69</td>
<td>25</td>
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<tr>
<td>AUS</td>
<td>45</td>
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<td>42</td>
<td>33</td>
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<tr>
<td>CAN</td>
<td>40</td>
<td>42</td>
</tr>
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</table>

Data collection: Harris Interactive, Inc.
Source: 2008 Commonwealth Fund International Health Policy Survey of Sicker Adults.
Why Focus on Access and Delay?

- Delays adversely effect clinical outcomes
- Delays lead to
  - patient dissatisfaction
  - staff dissatisfaction
  - provider dissatisfaction
- Delays
  - cost money
  - Reduce our efficiency and capacity
- The perception is that delay = lack of resources
Family Practice Environment in Alberta:

- Sicker patients
- Unassigned patients
- Fewer beds
- Longer waits
- Shortages

It just doesn’t feel good to practice like this:
- Overwhelmed with the volume of work
- No time to interact with other providers like Home care, etc
- No time to provide the quality of care we all want
- No time for our families and us
- A feeling of unmet responsibilities
- A response of general ‘withdrawal’ of services

Moore, Escaping the Tyranny of the Urgent by Delivering Planned Care. 
*Family Practice Management.* May 2006
40 PCNs so far in Alberta

- Networks of between 3 to 200 FPs and clinics (most are ~30)
- 80% of the Alberta FP population
- >2.5 million rostered patients, with a goal of 80% of Ab pop by the end of this year

- Provincially defined set of core services, with each PCN emphasizing different services based on local needs
- Supplementary funding to support enhanced staffing and teams
- Funded renovations, facilities and equipment to support teams
- Enhanced payment for Chronic Disease Management
- Extended office hours
Alberta AIM: Access, Improvement, Measurement

Initial interest generated through the IHI Breakthrough Series on Office Practice Redesign (‘Advanced Access’)

- A structured improvement process with proven successes internationally

• Now a provincial initiative available to Primary Care Networks supported by Alberta Health, AMA, and the Health Regions
Alberta AIM: Access, Improvement, Measurement

The Goals of AIM

- Improved access for appts
- Improved efficiency at appts
- Improved Clinical Care thro teams

The ‘Mantra’ of AIM

“Know your own patients”
“See your own patients”
“Don’t make them wait”

Moore, Escaping the Tyranny of the Urgent by Delivering Planned Care. *Family Practice Management*. May 2006

Brousseau, et al. Association Between Infant Continuity of Care and Pediatric Emergency Department Utilization *Pediatrics* Apr 2004

What else do our patients value?

• “Amiability”... Relationship

A key aspect of what people value about health care is a direct and ongoing relationship with a specific provider/team... “continuity”, “longitudinality”, “connectedness”

• “human relationships”
• “Connectedness”
• “time to care”
• the “opportunity to share decisions”.

“Good care is about people” WHO Report 2008

**WHO Report 2008**: Primary Healthcare Reform: Now, More than ever
Principle: Panels and Registries
or “Validated Patient Lists”
(“Know your own patients.”)

Panel Size 2000

- 360 Patients are Over 65
- 60 Patients had more than 10 Office Visits Last Year
- 130 are Clinically Depressed
- 228 have Hypertension
- 248 have Arthritis
- 160 have Heart Disease
- 66 have Diabetes
- 113 have Asthma
Advantages of a panel

• The team is in a position to supplement the doctor-patient dyad in order for it to be successful
  – The screening and chronic disease care needs of the patient population can be clearly identified, as well as urgent care needs
  – Elderly moving into supportive and long term living facilities remain under the responsible family physician
    • In addition to payment for services provided (FFS), each pt assigned generates an additional payment of $50/yr
    • Utilized to fund additional team based service relevant to local needs.

• Shift away from episodic visits by individual patients to management of a specific and defined patient population.
Principle: Continuity
(“See your own patients”)

- When patients see their own physician
  - Visit length is shorter and compliance is better.
  - Chance of ‘re-visit’ goes down
  - Patient, physician, and staff satisfaction rise,
  - costs go down, revenue rises,
  - Earlier detection of serious illness
  - and clinical care and outcomes improve.
  - Increased sense of ownership by provider, patient and team.

- Patients know their Family Doctor
- Doctor knows “which patients are mine”
- Both feel accountable to each other.
What else do we as providers value?

• “Ability”...Quality of Care
  – What I spent all these years in school doing
  – Dr House- The Good, the Bad, and the Ugly-
    • never miss a diagnosis
    • always providing the most relevant and up to date treatments
    • having the courage to fight for the patient.

  – But in trying to do it all, we as docs, working alone don’t do enough.
The Canadian health system is not healthy!
(Health quality council of Canada. 2007)

Only 1/3 to ½ of the evidence-based, guideline level recommended treatments are done.

Hypertension
• One of four adults, <1/3 are controlled, 1/3 don’t know they have it

Diabetes
• 60% have gone >1yr without an examination
• 44% of Diabetics meet Canadian guidelines of care (2006)

Heart Failure
• ~20% of heart failure patients are readmitted <60 days

Asthma
• Third leading cause of presentation to ER

Screening
• 38% of eligible women in Alberta get Pap screening
• <10% of those with indications for colon screening (CMAJ, 2007)
**Principle: Improve Clinical Care**

**Pre-Plan and Standardize Care provided by the Team**

- Identify the Clinical Profile of each physicians’ ‘panel’ of patients
  - Identify Patients with Targeted Conditions
  - Identify the Screening and Prevention Needs for that specific patient population
  - Identify complex Patients for case management
  - Health screening, Prevention, Ongoing Management of Chronic Diseases

**Plan our Team Responses for Patient Needs**

- Embed clinical protocols and guidelines to assist the team and reduce variations in practice.

Using the Clinical Guides on HTN, protocols were developed:
- To establish diagnosis
- Risk stratification
- Non pharmacological interventions and education

Roles were assigned to various team members as per their scopes of practice.

Patients with established diagnosis were then referred back to the FP for individual action plans re: meds, exercise, etc

Patients not at target are immediately discussed with the patients identified doctor for further management
Patient Label

Doctor

Date

Risk Factors: ____________________________ Target BP: ______

HTN Pathway: Not Yet Diagnosed

Elevated BP: [ ]
Follow up appt with LPN/ RN (one week) Date: ____________

NURSE VISIT ONE: BP [ ]
* If BP > 180/110 notify physician for possible diagnosis of HTN
  □ Order lab work   □ Initiate lifestyle teaching
  □ Complete cardio view data sheet
Follow up appt with nurse (one week) Date: ____________

NURSE VISIT TWO: BP [ ]
* If BP > 160/100 notify physician for possible diagnosis of HTN
  □ Consider initiating 24hr BP or home monitoring
  □ Review cardio view results and overall risk factors
  □ Review lab results
  □ Reinforce lifestyle modifications
  □ Offer BHL classes for risk factors
Follow up appt with nurse (one week) Date: ____________

NURSE VISIT THREE: BP [ ]
* If pt has target organ damage and BP > 140/100 notify physician for diagnosis or
  if pt has no target organ damage and BP > 160/100 notify physician for diagnosis of HTN
  □ Refer to physician for diagnosis of HTN (one week)
  □ Complete an ECG

Positive Diagnosis: Initiate HTN pathway

NOTE:
At least two BP should be done.
If BP < 140/90 and no target organ damage then review BP yearly
24hr BP monitoring may be done at any time per physician request
ER Visits for Asthma: Taber

Taber Asthma Program

Family Practice Teams
“Metrics Matter”

🌟 “Drumbeat of Change”
- Routinely measure and compare

🌟 Demonstrate the changes made and effort extended actually resulted in improvement

🌟 Several Canadian Resource and Measurement tools
- Quality in Family Practice - McMaster U
- Alberta AIM Measurement Excel spreadsheet: www.albertaaim.ca
- Ontario: www.ohqc.ca and also www.qiip.ca;
- IMPactBC online measurement package

🌟 International resources and measurement tools are available
- www.clinicalmicrosystems.org
- www.improvingchroniccare.org
- www.howsyourhealth.org
Publically Prioritized Quality Indicators

• Access
  – Next available appt, phone access to md, acceptance of new pts

• Integrated teams
  – Continuity of care

• Quality of Care
  – Screening for illness
  – Clinical care of diabetes, COPD, CVD, bp control
  – Utilization of ER and hospitalization for ACSC

• Self Care Support
  – Counselling re activity, tobacco, healthy eating,
  – Rates of healthy eating, smoking, activity, Quality of life
  – Respect and empathy, participation in decisions, trust, time spent

Boivin et al. Target for improvement: a cluster randomised trial of public involvement in quality-indicator prioritisation Implementation Science 2011
Outcomes

• Satisfaction
  – Health providers are significantly happier with:
    • Communication flow and information sharing
    • ability to impact patient health behaviors
    • improved job satisfaction
    • MORE autonomy in the performance of their jobs.
    • Current work situation

  – Patient and Community satisfaction remained high.

Outcomes

• **Physician Services**
  – Progressive decrease in the rate of physician visits/pt
    • Rates of non-physician services increased
    • Absolute number of physician services increased
    • Avg return rate: 2.1 visits/yr (cf. control communities: 5.6 visits/yr)

• **Utilization**
  – Taber hospital admissions decreased
    • Morbidity index and ALOS increased significantly
    • 78% occupancy (cf. control communities: >100% occupancy)
  – Emergency room visits decreased
  – Lab utilization decreased

A CPCN Clinic
YR 1 - 2006
Blood Pressure Process
Pull charts for patients age 18 and over. Audit random sample of 10 charts per provider where BP was taken at most recent visit.

A CPCN Clinic
YR 2 - 2007
Blood Pressure Process
Documented evidence of Blood Pressure taken for a random sample of female patients 18 yrs and over per provider
CPCN Regional Averages 2007 - 2010

<table>
<thead>
<tr>
<th>Category</th>
<th>Jan-Dec07</th>
<th>Jan-Dec08</th>
<th>Jan-Dec09</th>
<th>Jul09-Jun10</th>
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<tbody>
<tr>
<td>Blood Pressure Process</td>
<td>46.64%</td>
<td>55.99%</td>
<td>63.49%</td>
<td>67.97%</td>
</tr>
<tr>
<td>Blood Pressure Outcome</td>
<td>74.27%</td>
<td>72.41%</td>
<td>72.88%</td>
<td>74.50%</td>
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<tr>
<td>Colorectal Cancer Screening</td>
<td>30.30%</td>
<td>32.24%</td>
<td>44.89%</td>
<td>50.62%</td>
</tr>
<tr>
<td>Pneumococcal Immunization</td>
<td>50.75%</td>
<td>44.40%</td>
<td>49.32%</td>
<td>52.71%</td>
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<tr>
<td>Cervical Cancer Screening</td>
<td>62.25%</td>
<td>60.72%</td>
<td>69.65%</td>
<td>71.77%</td>
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<tr>
<td>Breast Cancer Screening</td>
<td>47.41%</td>
<td>49.12%</td>
<td>58.63%</td>
<td>59.07%</td>
</tr>
<tr>
<td>Tobacco Usage</td>
<td>18.05%</td>
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<td>28.88%</td>
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<tr>
<td>Weight Classification</td>
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<td>7.23%</td>
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Colorectal Cancer Screening & Patient Compliance

Mean = 57.2%

CPCN Regional Clinic Average
(July 1 2009 - June 30 2010)
<table>
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<tr>
<th></th>
<th>Blood Pressure Process</th>
<th>Blood Pressure Outcome</th>
<th>Colorectal Cancer Screening</th>
<th>Cervical Cancer Screening</th>
<th>Breast Cancer Screening</th>
<th>Pneumococcal Immunization</th>
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<td>48.4</td>
<td>53.3</td>
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<tr>
<td>63.9</td>
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<td>71.4</td>
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<tr>
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<td>72.7</td>
<td>67.4</td>
<td>57.9</td>
<td></td>
<td>51.5</td>
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### Blood Pressure Process

#### Blood Pressure Taken within the previous 12 months

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<tr>
<th>Month</th>
<th>A</th>
<th>B</th>
<th>C</th>
<th>D</th>
<th>E</th>
<th>F</th>
<th>G</th>
<th>H</th>
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<td>Dec 07</td>
<td>60.6</td>
<td>46.2</td>
<td>43.0</td>
<td>43.7</td>
<td>35.5</td>
<td>31.0</td>
<td>32.0</td>
<td>62.8</td>
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<td>Dec 08</td>
<td>59.0</td>
<td>55.5</td>
<td>46.5</td>
<td>52.5</td>
<td>46.9</td>
<td>37.6</td>
<td>42.5</td>
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<tr>
<td>Dec 09</td>
<td>76.5</td>
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<td>73.0</td>
<td>65.0</td>
<td>57.9</td>
<td>61.1</td>
<td>47.5</td>
<td>67.0</td>
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<td>09-Jun 10</td>
<td>79.5</td>
<td>79.5</td>
<td>70.5</td>
<td>77.5</td>
<td>86.3</td>
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<td>68.8</td>
<td>62.0</td>
<td>74.4</td>
<td>74.9</td>
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</table>
References

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- Ontario Quality Health Council Quality Improvement Guides.
  - www.oqhc.ca

- Chinook Primary Care Network
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  - www.albertaaim.ca