A context of primary care reform

• Primary care (PHC) reform is currently under way in various Canadian provinces
  – Recognition of the central role of primary care into healthcare systems’ performance

• Emerging models and policies are at various levels of implementation across jurisdictions
  – A natural experiment of change in primary care
A need for an integrated perspective

• There have been some evaluations of these reforms, few cross provincial analyses
  – Lack of interprovincial studies;
  – Variations in designs and measurement instruments;
  – Few documentation of the impact of contexts on the implementation and impact of PHC reforms
The goal of the study

• The aim of this study is:
  – to better understand the impact of emerging models and policies and;
  – to identify the factors that have been facilitating or hindering their implementation
Outline of the panel

• Introduction and methods – 10 minutes
• Provincial case studies – 50 minutes
  – British Columbia
  – Manitoba
  – Ontario
  – Quebec
  – Nova Scotia
• Discussion – 10 minutes
• Questions and exchange – 20 minutes
# Healthcare system structure framework

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Barriers and facilitators framework

- Coercive influences
  - Laws, regulations and policies

- Normative influences
  - Professional norms and values

- Mimetic influences
  - Innovators and champions

- Receptivity to change
  - Internal openness to change

PHC change
A qualitative process

1. Published and grey literature synthesis
2. Interview / survey of observers of PHC reform models
3. Production of preconference material
4. Revision and submission to participants
5. Discussion and deliberative revision
6. Report writing / feeding into research project
Primary care reform in British Columbia

Sabrina Wong, RN, PhD
Associate Professor, UBC School of Nursing and Centre for Health Services and Policy Research
Primary care reform in BC

- Post PHCTF.....establishment of GPSC (General Practice Service Committee in 2002; co-chaired by BC Medical Association and BC Ministry of Health Services
  - Receive a growing budget from province, about $200 million in 2011-12
  - focus on financial incentives to promote evidence-based care by full-service family physicians ($800 million investment from 2002-12)
  - Clinical, office management, and structural support to family physicians

- Maintenance of fee-for-service with incentives
- Move away from team-based care
BC’s strategy for change

• Collaborative effort by BCMA and BC Ministry of Health Services (representatives from BCMA and BC MOHS)
  – Engagement of family physicians and ‘no attempt to restructure the primary healthcare system’

• 15 different types of incentives; care delivery for chronic and complex care, orphaned patients, participation in training programs such as practice support (group medical visits, patient self-management)

• Divisions of Family Practice (n=30)-organizes groups of GPs at the local level to address common healthcare goals and link solo or small-group practice physicians into a supportive network
BC’s context of reform

• Shortage of PHC providers in BC-training of MDs and Nurse Practitioners (NPs) ramped up in past 10 years; NPs are trained to deliver PHC in BC; many remain jobless

• Planning for PHC service delivery based on engagement of one profession

• All future PHC reform will arise from GP Divisions of Practice
  – Expectation that Divisions will work to integrate public health, health authority
  – Divisions will work to ‘attach’ patients to practices
Barriers and facilitators

• **Barriers:**
  – Fee-for-service
  – Incentives/pay for performance of some types of care
  – Lack of funding for other models of PHC delivery
  – Lack of representation of other stakeholder groups on GPSC
  – Slow uptake of electronic medical records due to privacy concerns

• **Funding without accountability to quality improvement**
The impact of reforms

- Strong working relationship between provincial government and family physicians
- Physicians participating in incentive programs have seen an average salary increase of: $27,000 (12%)
- Move away from team based care to physician-patient relationship
- Barriers to Nurse Practitioners providing primary health care due to funding issues
- Lack of evaluation of reform on patient outcomes
The take home message

• Rigorous evaluation and research on how PHC reform influences patient outcomes is needed
• Performance measurement system in PHC can assist in provision of evidence
Primary Care Reform in Manitoba

CAHSPR 2011
Alan Katz
Change in Manitoba

- Environment: recognition of PC as foundation of the system
- Physician Integrated Network (PIN) – 20% of FPs
- Advance Access
- EMR qualification/support
- Primary care networks
- Telehealth
Strategy for Change

- Quality based incentive funding (P4P)
- Change management
- Incremental change
- EMR for data collection
- Focus on fee-for-service
Context

• Regionalization
• Political focus on the headlines (ER, Mental health, Neurosurgery)
• Political environment: Strong medical association committed to FFS
• Geography (Winnipeg 67% of population)
• Shortage of FPs (rural)
Barriers to Change

- Manitoba Health
  - Funding
  - RHAs: service delivery

- Medical Association (DM)
  - Negotiation
  - Representation

- Family Physicians
  - FFS payment

ONE UNIVERSITY. MANY FUTURES.
Impact of reforms

- EMR use fundamentally changed
- Prevention (Population at Risk)
- Regional collaboration
- Interdisciplinary teams
- Roster definition/identification
Take home messages

• Provider engagement has been critical but is only possible with an incremental approach

• Hampered by the lack of willingness to move to more formal patient-physician relationship
Primary care reform in Ontario

William Hogg
Virtually every aspect of my work has changed

• Rostering

• Computerization

• Blended Payment system

• Interdisciplinary Teams
The Change Process

• Voluntary

• Step wise

• Change was supported

• Scope
Ontario’s context of reform: barriers

- Complacency / arrogance
- Lack of performance data
- Ontario Medical association
Facilitators

• Cost
• Access problems
• Performance data
• Research on high performing systems
• Medical specialist support
The impact of reforms

• The change was harder than expected

• The change took longer than expected

• The benefits were different than expected
Questions

• Will the government stay the course?

• Is it too expensive?

• Which AHPs should join?

• Is there gaming?
The take home message

• Finish what has been started
• Optimize
• Integration
Primary care reform in Québec

Jeannine Haggerty
Primary care reform in Quebec

Reform model: *Groupe de médecine de famille* (GMF) Family Medicine Group

- Group practice, 8-10 doctors
- Service contract with regional authority: 1300 registered patients per MD; extended service hours; call arrangements for vulnerable patients
- Benefits: space rental; information technology and support; nurse “hired” by Group, paid by CLSC.
- Physician remuneration: FFS with fee structure for coordination; registration fee NOT capitation
- Contract renewable after 5 years

2002 – 18; 2010 - 216 FMG (GMF)
Québec’s strategy for change

• Volunteer uptake
• GMF support unit created in the MoH to help volunteer practices apply for and adopt model
• Regional Divisions of General Practice (DRMG) integrated into regional health authorities: local legitimacy; real clout
• 2005: Mandated creation of local health networks; administrative merger; population health mandate.
Québec’s context of reform

• GP shortage (25% w/o FP, 40% Montreal)

• 2000 Clair Commission:
  – Portrait of difficult access, fragmented care
  – Primary care targeted for reform; integration of private (medical) and CLSC (social) networks Family Medicine Groups (GMF)

• No NPs. But 2003 Redefinition of the health professionals act expands nursing role; GP & nurse unions collaborate in delegated medical acts (NPs in 2008)
Barriers and facilitators

- Facilitators:
  - Appetite for change (unanticipated)
  - $$ Primary Health Care Transition Fund $$
  - Professions regulations and collaboration
  - Coherent policies: DRMG, LHN,

- Barriers
  - One-size does NOT fill all (rural, metropolitan)
  - Administrative burden
  - Support was not initially solid.
The impact of reforms

• Nurse-Physician collaboration improves systematic chronic disease follow-up where nursing role fully deployed; uneven deployment; limited disease coverage.

• Enhanced accessibility for enrolled patients; no advance for those without family physicians.

• Autonomous physicians active participants in health policy and system change; opens door to broader change
The take home message

• Achieving a critical mass made accessible team care the new normal and opened the door for broader change beyond the GMF (for affiliated patients).

• Successful critical mass:
  – Funding injection
  – Adaptability of model to contexts.
  – Synergy with other policies
  – Physician leadership and organized medicine
Primary Care Reform in Nova Scotia

Fred Burge, MD
Professor,
Family Medicine and Community Health and Epidemiology
Nova Scotia Context

• #1 or #2 in Canada for:
  – death from cancer, circulatory and respiratory disease
  – diabetes
  – arthritis and rheumatism
  – depression

• Oldest population in country (16% over 65)

• Unemployment rate 9.2%

• 3rd highest debt/GDP ratio in country
Nova Scotia Context

- Population 930,000
- District Health Authorities: 9
- Per cent with a FP: 95%
- FPs: 960
- NPs in PHC: 45
- FPNs: 100
- FPs using EMRs: 380
- Other HCP using EMRs: 300
- “Known” collaborative PHC teams: 50+
Nova Scotia’s context of reform

- Collaborative practice arrangements between NPs and physicians (health professional legislation)
- Physician association’s slowly moving forward with reform ideas as they relate to physicians
- A relatively ‘poor’ province financially and challenged re new investment
- ‘Incremental changes’
- Population orientation (needs based, community based)
Nova Scotia’s strategy for change

– Building a better tomorrow (today)
– Primary Healthcare Information Management
– Healthlink 811
– Collaborative teams
  • Collaborative FP:NP teams
  • Family Practice Nurse Initiative
  • Community Health Teams
  • Novel paramedic roles
  • Open access
– More recently:
  • Growth of FPNI
  • New LTC NPs
  • Care by design and Advanced Care-paramedic
  • New Pharmacy legislation
  • Collaborative emergency centres
  • Quality collaboratives
  • Urgent care centres
Barriers and facilitators

• Physician payment model a barrier
• Physician incentive payments helpful
  – Chronic disease care
  – EMR uptake and realized usage
• Practice-based and community leadership and innovation (DDFP/PHC CDHA)
• Enthusiasm of other providers to grow capacity in PHC: nursing, pharmacy, paramedics, self-management teams
• Not leaping into larger scale ‘disruptive’ transformative change within PHC organizations
The impact of reforms

- PHC Collaborative Team Survey
  - 55 teams participated
  - Small FP/RN/admin
- Individual program evaluations, not published
- Most are before after evaluations of both outputs and outcomes
- FPNI, paramedic, care by design, NP
- Access, satisfaction and clinical care measures
- We know some improvements in access, patient satisfaction and clinical care have occurred
The take home message

• Our ‘reform’ is incremental and principle based
  – What are outcomes like for this vs large model change?
• Our ‘reform’ is challenged by our fiscal reality (need to stay focussed)
  – How can we shift budget to PHC?
• But change can happen despite this
  – How to support innovation/change with limited dollars?
• Need more evidence about the outcomes of such incremental change in meeting goals
  – How to report small « n » results of change that are meaningful?
Discussion
A heterogeneous portrait

• Variability in types of PHC reform implemented
• Various levers for change mobilised
• Some documented impacts of reform
• Some recurrent themes across the provincial case studies
Impacts of reform

• Most benefits of the reforms so far seem to have occurred with regards to
  – patients’ affiliation with a usual source of care,
  – some benefit on the experience of care of patients,
  – and a higher workforce satisfaction
Barriers to change

• The main barriers to reform were
  – the lack of financial investments in the reforms,
  – resistance from professional associations,
  – too prescriptive approaches lacking adaptability,
  – and an overly centralised governance model.
Facilitators to change

• The main facilitators were,
  – a strong financial commitment using various allocation and payments models,
  – the co-option of professional associations through the process of reform,
  – an incremental emergent change philosophy based on a strong decentralisation of decisions and adaptation to local circumstances.
Coercive influences

PHC change
A strong role for governments

“The driving force for reform has come mainly from governments, with the climate among providers being either neutral to favourable. Although reforms are now accepted and seen as necessary, few cases of active lobbying from within the profession for new organizational models have been observed.”
Legislative tools for change

“For the most part, influential legislation has consisted of the various acts regulating the expanded role of other health professionals in primary care.”
A dual influence of funding mechanisms

“Too much funding or too little of it has been identified by the forum participants as critical. Increased remuneration and financial incentives were necessary and have been successful in transforming practices and engaging physicians in the reform process.”
Normative influences

PHC change
An emerging collaboration between governments and professional associations

“Few changes have been imposed on providers in recent years and it is more a discourse of incentives or demonstrations that is currently seen in many provinces. In many cases, the need to treat physicians as partners in reforms was identified as the key to success.”
Developing collaborative practices

“... the new leadership role of physicians was also raised by some participants as a factor supporting or in some instances possibly hindering the reform process. Physicians are now asked to take on a new leadership role in not only their practice but also in governance.”
Mimetic influences

PHC change
The importance of innovators and champions

“...in every province, the presence of certain champions among primary care providers has been crucial and they have often acted as role models for other physicians in order to generate the necessary uptake for new models or initiatives to grow.”
The importance of innovators and champions

“ In some cases, the provincial chapters of the College of Family Physicians, as well as the chairs of family medicine departments of various universities across the country, have also taken an enabling and active role.”
Receptivity to change

PHC change
A supportive socio-political context

“If the policy environment has historically been neutral towards primary care and professionals generally opposed to the redesign of their practice, it is clear that the current socio-political context has changed throughout the country.”
A felt urgency for change

“A strong desire for change has been observed in many provinces. Physicians are seeing their workloads increase because of the shortage of human resources relative to the increased complexity of clinical cases. Many are now more receptive to changes.”
Conclusion
A momentum for change

“The environment of primary care reform has changed considerably in the last decade. Collaboration between governments and local health jurisdictions and physicians has increased and structures have been put into place to work collaboratively.”
The governments’ choice of strategies

“Many provinces have opted for quality-based incentive funding and pay-for-performance instead of large-scale redesign. Some provinces are more advanced in redesigning primary care through the introduction of new models. In many cases, the need to approach reforms in a slow and incremental fashion was chosen in order to mobilize providers.”