Primary Health Care Summit

Summary Report

January 25 – 26, 2012

Ottawa, Ontario

Hosted by: Canadian Nurses Association and Canadian Medical Association

Acknowledgement

The Canadian Nurses Association and the Canadian Medical Association gratefully acknowledges the funding support provided by Health Canada that made this Summit possible.

Disclaimer

The views expressed in this report are those of the participants and not necessarily those of the Canadian Nurses Association, the Canadian Medical Association, nor Health Canada.

Summary Report prepared by

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Introduction and Background

The Canadian Nurses Association (CNA) and the Canadian Medical Association (CMA) partnered in convening a multiple stakeholder summit focused on Primary Health Care (PHC). The proposed purpose of the summit is to identify key opportunities and mechanisms to support the integration and implementation of PHC across Canada.

A core planning group with representatives from CNA, CMA and Health Canada guided the design of the Summit, identification of participants and agenda for the 1.5 days. See Appendix A: Summit Agenda. Prior to the Summit, participants were provided with a selection of readings to provide a common foundation and generate dialogue contributing to the objectives identified for the Summit.

Summit Objectives:

1. Explore fresh perspectives, promising practices and key enablers to advancing Primary Health Care (PHC).
2. To identify policies and mechanisms to increase access to quality PHC for Canadians.
3. To identify how PHC can be fully integrated into the Canadian health care system.

The Primary Health Care Summit was envisioned as an opportunity to bring together a variety of thought leaders to engage in information sharing, critical dialogue and generation of ideas and strategies for advancing Primary Health Care. The intent was not to generate specific recommendations that would be carried forward by CNA or CMA, on behalf of the participants. The information contained here is a summary of the key messages generated from the Summit that can be used not only by CNA, CMA and Health Canada, but by all participants and their respective organizations and jurisdictions, as a means of individually and collectively stimulate the implementation of strategies and mechanisms to support the full integration of PHC into the health care system.

Participants

A total of 30 participants attended the Summit. The invited participants reflected a wide range of professional backgrounds (e.g. clinical, research, policy, and education), jurisdictions (e.g. British Columbia, Saskatchewan, New Brunswick, Quebec, Alberta, and Ontario), and the public (e.g. patient representative).   See Appendix B: Participant list

The key messages and recommendations reflect the themes expressed throughout the summit and are presented here and augmented with *italicized excerpts* of participant comments drawn from the audio recording of the sessions. There are no names directly linked to the excerpts provided here.

Setting the Context

To set the context for the Summit, Judith Shamian (President, CNA) provided a high level overview of primary health care including the following definitions to differentiate between Primary Health Care and Primary Care.

Primary health care (PHC) is community-based, promotes healthy lifestyles as a pathway to disease and injury prevention, provides continuing care of chronic conditions, and recognizes the importance of the broad determinants of health. It embraces a wide suite of services and involves a broad range of health-care providers (CIHI, 2006).

Primary care is defined as "a service at the entrance to the healthcare system. It addresses diagnosis, ongoing treatment and the management of health conditions, as well as health promotion and disease and injury prevention. Primary care is responsible for coordinating the care of patients and integrating their care with the rest of the health system by enabling access to other healthcare providers and services" (Kingston-Riechers et al., 2010, p. 6).

Despite the initiatives current and past, there remains the sense that barriers exist to advancing PHC. Some examples of the reasons for so little progress included: lack of integration across the continuum, lack of intersectoral approach, lack of clarity regarding compensation, and the barriers to interprofessional collaboration and optimizing scope of practice and utilization of health care professionals (CNA, in press).

Promising recent develops in the area of primary health include the Canadian Institute of Health Research (CIHR) Signature Initiative to fund research that supports the delivery of high-quality, Community-Based Primary Health Care, and the Canadian Primary Health Care Research and Innovation Network a newly established organization of researchers from all primary health care (PHC) research disciplines and experts from all stakeholder groups interested in primary health care.

One Jurisdiction's Experience

With recognition of the several initiatives underway in various jurisdictions, Andrea Wagner (Director, Primary Health Services Branch, Government of Saskatchewan) provided an overview of the recently developed Saskatchewan framework for achieving a PHC system. This provided an example of one jurisdictions' approach to advancing PHC to enable sharing and collective dialogue among the Summit participants. The report entitled Patient Centred, Community Designed, Team Delivered: A framework for achieving a high performing primary health care system in Saskatchewan synthesizes the perspectives of more than 400 people including community leaders, patients, providers, policy-makers and managers and outlines their shared vision for a sustainable primary health care system. The building blocks described in the framework include:

1. *Relationships as the foundation:* Relationships between communities, Regional Health Authorities, and providers, are critical to the success of primary health care in Saskatchewan.
2. *Increased patient and family self-reliance:* Equipped with information and the right supports and tools, patients and families can do a great deal to manage their own health.
3. *Engage communities, including First Nations and Metis*, in service model design: Community engagement is essential in building the relationships and trust required to assess needs, plan solutions, implement solutions, and evaluates effectiveness of any new primary health care models. Anything developed for the community must begin by involving the community.
4. *Enable primary care teams to flourish :* Team-based health care has huge untapped potential, but there are numerous factors that contribute to - or sabotage - a team's success
5. *Take a Proactive Approach to Chronic Disease Prevention & Management:* primary health care needs to fully engage with population health programs and other inter - sectoral partners in a coordinated effort to prevent, reduce, and manage chronic disease.
6. *Engage in Building Models that Work*: The perspectives of patients and families must be incorporated into the design and ongoing delivery of primary health care services.
7. *Policy and Accountability*: It must be made clear what outcomes regional health authorities and health care providers are responsible for achieving and to whom they are accountable.
8. *Support through the Transition*: Changing how we delivery primary health care will mean significant change for everyone, from patient to provider. United by our shared desire for a patient and family-centred health system and healthier population, we can and must work together and support each other through the transition.

It's about doing with – not doing to. We are not advocating for one model. Quality improvement is the how we will get there; learning by doing, then scale up and spread.

The importance of Primary Health Care and identifying the barriers to progress.

The following sections provide a summary of the dialogue among Summit participants regarding the importance of PHC and the barriers to advancing PHC forward.

<u>What makes PHC important and meaningful?</u>

1. PHC is the centre of the system.

   Primary Health Care is the most commonly used "front door" to the health care system as evidenced by the *Ecology of Medical Care* (Green et al, 2001) which determined that for every 1000 persons, 217 will visit a physician's office as compared to 8 who will actually require hospitalization. See Figure 1: Ecology of Medical Care.

This is where most people get most of their professional care, most of the time and the system does not recognize the scale of this effect and the system was never been designed around this fact.

Recognition that primary health care is the hub of the person's health journey in that despite the episodes of care required, people return to primary care at various points in their health care journey. See Figure 2: Primary Health Care Model

The system is not designed with primary health care at the centre of the system, yet it crosses the continuum, anchors the journey and should make the person's journey through the health system easier.

Need to see greater connection to public health on one end and the community and continuing care on the other; it's not just about acute care and managing illness.

2. There is an appetite for change as evidenced by the many innovations.

   There are a variety of models in place, reinforcing the concept that one size does not fit all and the importance of considering contextual factors when determining care delivery models.

   There are several pockets of success, but they are often few and far between and often isolated, with results not shared beyond the local area of implementation and/or impact.

3. The principles of PHC are consistent with Canadian values regarding health and health care.

   Canadians tell us they want to be able to access health care services within their communities and expect to be treated as partners, not passive recipients, in their health care.

4. The heightened focus on fiscal accountability and quality outcomes.

   The high cost associated with treating illness within the acute care setting is pushing the care away from hospitals and back into the community.

   There needs to be increased focus on health promotion and prevention rather than a continued focus on the management of illness and disease.

If we know what the barriers are, what is holding back change/ progress?

1. PHC system *is not* a system as there is a lack of infrastructure to support fundamental change. The diversity of perspectives has resulted in a the lack of a collective voice on the fundamental issues and strategies required to advance PHC

There is no system that we can leverage to change. There are great examples but little spread. The lack of a system is fundamental. How do you create a functionally integrated system from all the separate components?

A common vision that realizes the foundational role of PHC to health system strengthening and improvement is notably absent. If we don't get it right at the community and population level, you see the results in the rest of the system – such as increased utilization of the Emergency Room, avoidable hospital admissions and delayed hospital discharges.

2. Lack of evidence related to outcomes

   There are many evaluation studies on specific programs and initiatives, but there is a lack of research on the impacts of PHC on persons, communities and populations.

   We seem to be looking for the answers or the perfect solution….we are now at the point where we need to just do it…and share the experience with others to spread the learnings.

   There is inconsistent adoption of standardized metrics (e.g. CIHI Pan-Canadian Primary Health Care indicators) and evaluation frameworks within and across sectors and jurisdictions to further describe and study PHC.

   Need to start with a small number of meaningful metrics that can be used across the various jurisdictions – international comparisons are also important.

   There is some good data on funding models just beginning to emerge that places emphasis of funding on quality and outcomes vs. volume.

3. Current legislation and regulatory challenges

   Provisions under the Canada Health Act are limited with respect to the coverage for health services. While physician and hospital care were seen as priorities when the Act was first introduced, this is no longer sufficient to optimize health and wellness in the 21st century.

   Remuneration models need to be revised to reflect team-based compensation not only physician-based compensation, with funding based on health outcomes and not volume.

   Continued and sustainable advancement is negatively impacted by 4 year political cycles that impact momentum and longer term planning.

   There is no coordinated approach to interprofessional health human resource planning as well as interprofessional health human resource planning requirements.

   The training of health care professionals is still conducted primarily in acute care settings with little emphasis on the roles of interprofessional team members.

There is a need to look at health human resource planning across professional groups – not just within each specific professions to determine the needs, utilization, distribution and possibilities.

4. The under investment in the competencies required by health care professionals, administrators and planners including areas such as change management, teamwork, quality improvement principles, tools and techniques.

   Don't underestimate the transition and support required, as there are many defenders of the status quo!

   Need to collaborate with academic programs to introduce students to the basic principles of change management, rapid cycle improvement and teamwork.

   Need to combine analytical skills with the skills of appreciative inquiry and evidence-based storytelling – using stories to make the information accessible; what stories can we share that provide the most meaningful explanation of what we are trying to achieve?

5. Access to health services (e.g. Emergency rooms, Urgent care centres).

   Need to get a better understanding of why people show up to Emergency rooms and Urgent Care Centers. What are the strategies for encouraging them to use a variety of resources?

   There is the phenomenon where some people will access services for minor issues and at the other end of the spectrum, others that do not (prolong) access needed services but should …. Both scenarios are costly to the health care system.

   We have evidence that patients rostered to a team, with a team based urgent care service, are less likely to use the service. They feel comfortable and secure knowing that they could access services if needed.

Priority Areas for Action: Pushing through the barriers and advancing PHC

The summit participants reached consensus on the following strategies for pushing through the barriers and advancing PHC in Canada.

1. <u>Development of a common set of core values and principles</u>

   Determine the foundational values and principles for moving forward. This can provide a common language and help guide and target efforts for system transformation.

   Be principle and value driven, not model driven.

   These core values and principles will act as a guide to determine the actions for getting there.

2. Build partnerships

Fostering relationships (e.g. professional, inter-sectoral) and community engagement as a vital foundation for continued growth and impact. The partnerships are to be based on the shared vision and principles for advancing PHC transformation.

Look for opportunities for public engagement at the local, regional, provincial and national levels to determie what the public expects and needs from PHC. This could also serve as an opportunity to provide education and build awareness regarding PHC.

Need to ensure the public is included in the partnerships in order to determine what the public supports and/or expects and then leverage this perspective to change and/or redesign the system.

There is a need for professional commitment and support from the relevant professional associations to carry this forward and maintain the momentum.

The national professional associations involved in PHC such as CNA, CMA, College of Family Physicians should lead those consultations together – should not be from an individual or self-interest perspective. Working together for better primary health care.

We need to do a better job of leveraging traditional and non-traditional partnerships such as eHealth, the Education sector, social services…ect.

Determine opportunities for building partnerships between providers, persons, researchers, decision-makers and educators to collectively inform policy makers.

3. Synthesis of the existing evidence and experiences

Enhance knowledge sharing of the models, systems, and implementation strategies used in order to enhance the sharing of lessons learned, amplify the effects and enhance the spread and scalability beyond the local level.

We need to move beyond being the "land of the pilots" and develop specific strategies to capture the knowledge and lessons learned from the various initiatives and build on the knowledge we have established, rather than duplicating efforts in isolation.

Be adventurous and go beyond the obvious partners to enable opportunities for leveraging what we know and accelerate success based on the skills that others have (e.g. advertisers, engineers).

Need to leverage existing resources …such as CIHI Pan-Canadian Primary Care Indicators.

Increase use of evidence-based storytelling and appreciative inquiry as purposeful strategies to make the information accessible and meaningful to multiple target audiences and all stakeholders.

Make use of informative examples, to encourage learning not only from the successes but from the mistakes.

Appreciative inquiry encourages asking questions in a way that heightens the positive potential rather than focusing only on the negative barriers and challenges.

Create a way of articulating such a compelling case that the public will demand that it happens!

4. <u>Support the development of innovative, integrated care delivery models</u>

PHC delivered by integrated, interprofessional health teams, incorporating a comprehensive model based on the needs and expectations of the person-community-population.

There is no one right model…!

We need to revisit the various PHC models and consider why what we have set up is not giving the results we are looking for. We know what to do, it's just the challenge of doing it.

Consider models in which patients are rostered to a physician versus patients being attached to a team, which may/may not include a physician as part of the team. If the patient is rostered to a team – what does that mean – where are the teams located and how do the physicians relate to these teams?

The notion of rostering can be a loaded term in that rostering is often linked to compensation models. We are more interested in idea of attachment, as we know there are far better outcomes when folks are attached to a family physician and an interprofessional team.

Most of the discussions about PHC are about how to engage physicians, and I get that they are a critical part of PHC, but there are other providers already out there that are part of a PHC team. Why don't we start building with what we've got instead of creating something brand new, why don't we build on the community assets already in place?

An alternative to building PHC teams and models is to first define the population, then attach them to a team of providers, and create an administrative structure to coordinate the funding and enhance community engagement.

The care delivery models are supported by a sustainable funding model that promotes interprofessional collaboration and places emphasis on quality outcomes and quality of care.

Compensation models need to be revised to reflect team-based compensation not only physician based compensation, with funding based on health outcomes and not volume.

Some physicians see themselves as a small business owner wanting to control their business while others view themselves as professional practitioners with someone else managing the shop. As we go forward, we need to look at both options.

First build the care delivery model to meet the needs of the community. Then determine how to fund that model!

5. <u>Understand and utilize the full potential of technology</u>

To better understand and optimize the use of information and communication technology, Web-based information and social media to enable and facilitate advancements in PHC.

Self-care is the largest part of the health care accessed and utilized by the general public. We have very little involvement in this aspect of care......so there is no systematic approach to supporting self-care. We need to build capacity with both providers and care recipients in this area

Health literacy, including e-health literacy is key to enabling self-care, with most self-care information being obtained from the internet.

How can we better utilize social media as a communication and education tool – for both the public and health care providers?

We need to look at the electronic health record as a mechanism to link health care providers; also ask the question - where is PHC in the dialogue regarding the development and implementation of the EHR?

6. Investing in change management and quality improvement to support the advancement of PHC

The advancement of PHC is fundamentally about large scale change management and quality improvement; therefore frameworks need to be built with these concepts and core competencies in mind.

First and foremost, we need to identify, embrace and communicate that the advancement of PHC requires a cultural shift that requires unique competencies and approaches.

Providers are locked into very traditional roles and comfort zones – change is happening but needs to be supported and accelerated.

These skills take time to develop and require support from experienced facilitators to create individual and team capacity…don't underestimate the support needed.

We need to collaborate with our academic and service partners to invest in the development of required competencies in our current and future interprofessional teams as well as for health care administrator and system planners.

Conclusions

The dialogue generated among Summit participants created consensus for the need to move beyond the identification of the barriers and challenges to advancing PHC (we've *had these conversations before, we know what the barriers are*). Many spoke of the need to focus attention, energy and resources on harnessing the existing information and evidence (*what we already know*) to advance primary health care within Canada.

Next Steps

The key messages generated from the Summit are intended to be used not only by CNA, CMA and Health Canada, but by all participants and their respective organizations as a means of individually and collectively implementing strategies and mechanisms to support the functional integration and implementation of PHC across Canada.

References

(including selected Pre-summit readings distributed to participants)

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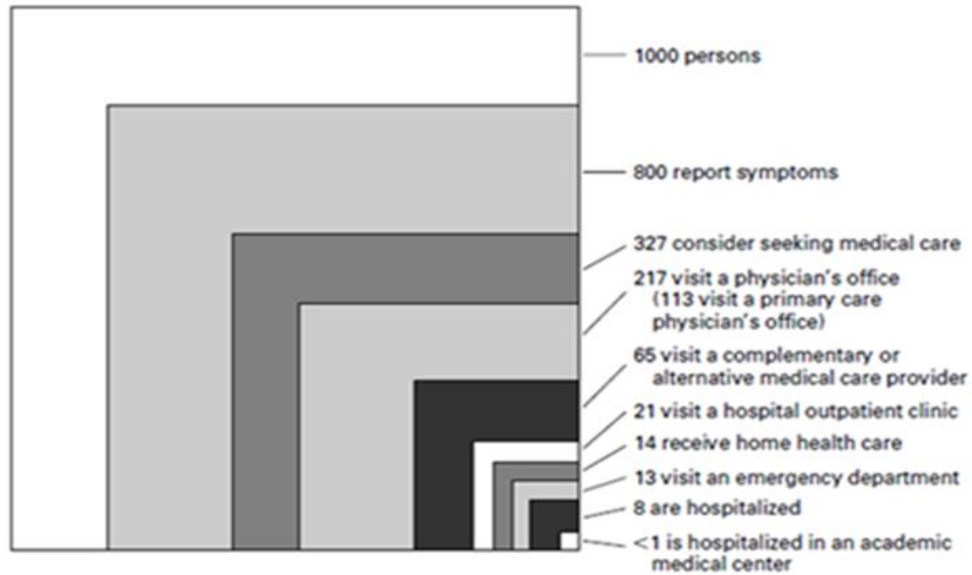
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Figure 1: From *Ecology of Medical Care Revised*. Green et al, 2001; NEJM. See Appendix G for original source.

1000 persons

800 report symptoms

327 consider seeking medical care

217 visit a physician's office
(113 visit a primary care physician's office)

65 visit a complementary or alternative medical care provider

21 visit a hospital outpatient clinic

14 receive home health care

13 visit an emergency department

8 are hospitalized

<1 is hospitalized in an academic medical center

Figure 2. Results of a Reanalysis of the Monthly Prevalence of Illness in the Community and the Roles of Various Sources of Health Care.
Each box represents a subgroup of the largest box, which comprises 1000 persons. Data are for persons of all ages.

Figure 2: Hub & Spoke Model for Primary Health Care
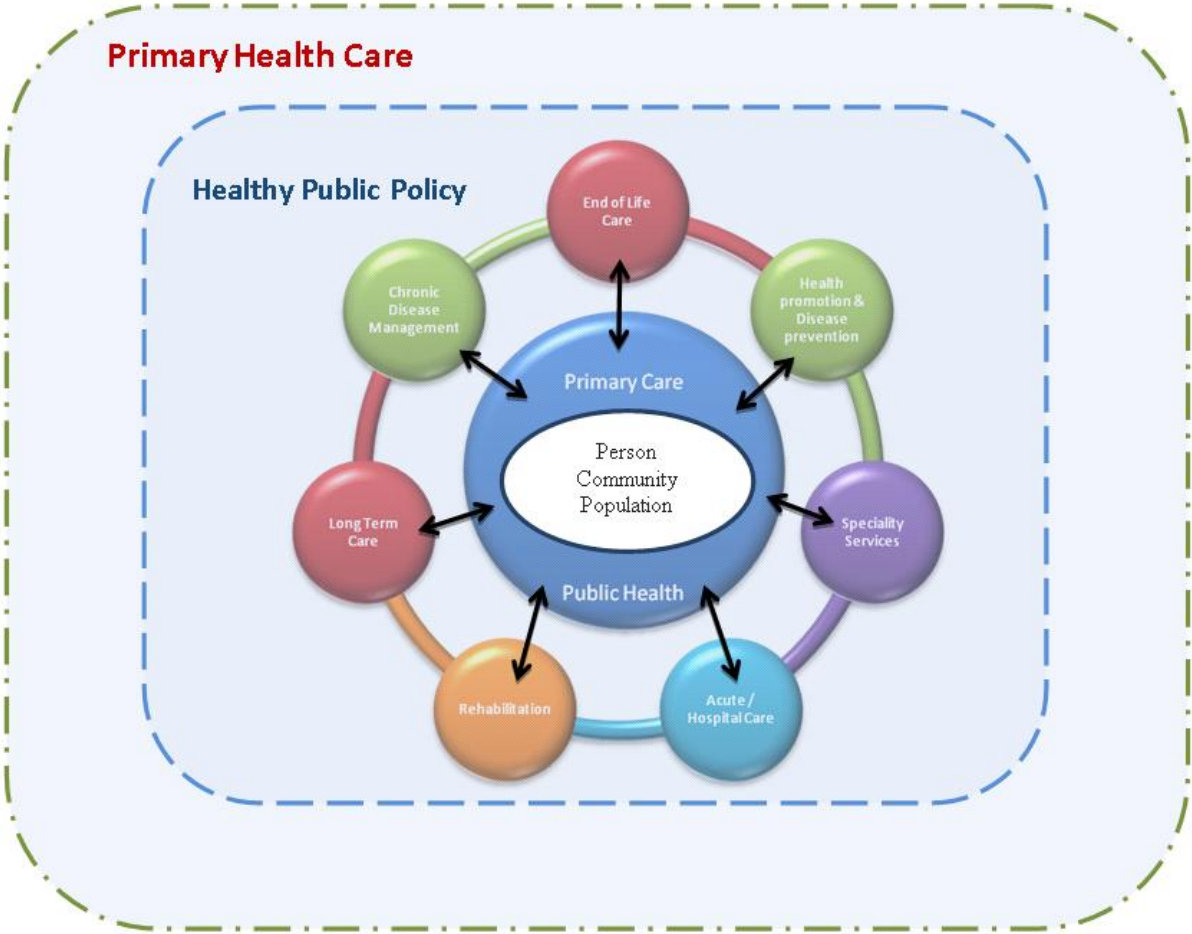
Appendix A: Summit Agenda

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Primary Health Care Summit
January 25 – 26, 2012
Canadian Nurses Association Boardroom
50 Driveway; Ottawa

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Objectives:
- Explore fresh perspectives, promising practices and key enablers to advancing PHC
- To identify policies and mechanisms to increase access to quality PHC for Canadians
- To identify how PHC can be fully integrated into the Canadian Health Care System

Pre-Reading: Please review the *PHC Summit – Relevant Readings* document distributed with this agenda

WEDNESDAY JANUARY 25, 2012	
Time	**Agenda Item**
12:00 – 1:00	*Arrival, Lunch*
1:00 – 4:30	**Welcome and Introductions ; Overview of Agenda & Process Consensus Decision-Making**
	Setting the Context : History & Current State of PHC in Canada
	Sharing One Jurisdiction's Plan for Advancing PHC
	Identifying & Prioritizing the Key Building Blocks for Advancing PHC in Canada
	Summary of Day 1; Review of the Plan for Day 2
THURSDAY JANUARY 26, 2012	
Time	**Agenda Item**
8:00 – 8:15	*Continental Breakfast*
8:15 – 12:15	**Fleshing out each of the Building Blocks identified on Day # 1**
12:15 – 1:00	*Lunch*
1:00 – 3:00	**Full integration of PHC within the Health Care System: What are the key actions required?**
	Pulling it together: What are the key messages to take forward – to whom and when?
3:00 – 3:30	**Closure, Next Steps**

Appendix B: Summit Participants

Participants	Positions and affiliations
Alba Dicenso	Professor, School of Nursing and Department of Clinical Epidemiology & Biostatistics, McMaster University
	Director, Ontario Training Centre in Health Services and Policy Research
Andrea Wagner	Director, Primary Health Services Branch, Government of Saskatchewan
Anne Buchanan	Patient representative/ advocate
Barbara Foster	Acting Executive Director, Office of Nursing Policy, Health Canada
Brian Hutchison	Professor Emeritus, Department of Family Medicine, Dept of Clinical Epidemiology & Biostatistics and the Centre for Health Economics and Policy Analysis, McMaster University
	Senior Advisor for Primary Care, Health Quality Ontario
	Co-Chair, Canadian Working Group for Primary Healthcare Improvement
Calvin Gutkin	Executive Director & Chief Executive Officer, College of Family Physicians of Canada
Claire Betker	Senior Knowledge Translation Specialist, National Collaborating Centre for Determinants of Health
David Gass	Physician Advisor, Nova Scotia Department of Health and Wellness
David Levine	Président-directeur general, Agence de la santé et des services sociaux de Montréal
Don Wildfong	Nurse Advisor, Policy and Leadership, Canadian Nurses Association
Dorothy Laplante	A/Executive Director, Office of Nursing Services, First Nations and Inuit Health Branch, Health Canada
Helen McElroy	Acting Director, Chronic and Continuing Care Division, Health Care Programs and Policy Directorate, Health Canada
Jeff Poston	Executive Director, Canadian Pharmacists Association
Judith Shamian	President, Canadian Nurses Association
June Webber	Director, Policy and Leadership, Canadian Nurses Association
Kendall Ho	Director, eHealth Strategy Office and Associate Professor, Division of Emergency Medicine, University of British Columbia
Linda Silas	President, Canadian Federation of Nurses Unions
Lisa Bonang	Vice Chair, GP Forum, Canadian Medical Association
Louise	Manager, Chronic and Continuing Care Division, Health Care Programs and

Participants	Positions and affiliations
Rosborough	Policy Directorate, Health Canada
Lynn DeGroot	Health Care Consultant, Primary Health Care (Unit), Government of NB
Martin Ducharme	Senior Policy Analyst, Primary Health Care Unit, Chronic and Continuing Care Division, Health Care Programs and Policy Directorate, Health Canada
Martin Vogel	Vice President, Community Building, Canadian Medical Association
Mary Martin-Smith	Nursing Faculty, SIAST and University of Regina Board Member, Canadian Public Health Association
Mike Villeneuve	Executive Lead, National Expert Commission
Owen Adams	Vice President, Health Policy and Research, Canadian Medical Association
Robert Wedel	Physician Lead, Chinook Primary Care Network, Lethbridge, Alberta Director of Chinook Palliative Care Program, Alberta Health Services Assistant Clinical Professor, University of Calgary
Ruta Valaitis	Dorothy C. Hall Chair in Primary Health Care Nursing Deputy Director, PAHO/WHO Collaborating Center on Primary Health Care Nursing and Health Human Resources Associate Professor, McMaster University
Ruth Martin-Misener	Associate Professor, School of Nursing, Dalhousie University
Sara Lankshear	President, Relevé Consulting Services **(Summit facilitator)**
Trevor Hancock	Professor and Senior Scholar, School of Public Health and Social Policy, University of Victoria
William Dalziel	Chief, Geriatric Day Hospital, Ottawa Hospital and Associate Professor, Geriatric Medicine , University of Ottawa

Appendix

Appendix	Description	Attachment
A	Agenda	PHC Summit Participant Agenda (1...
B	Participant list	List of participants.doc
C	Selected Pre-readings	PHC Summitt - Relevant Readings_V7
D	Presentation: Primary Health Care Judith Shamian	PHC Summit - J Shamian.ppt
E	Presentation : Saskatchewan Blueprint Andrea Wagner	Saskatchewan Blueprint.ppt
F	Summit Day 1 : Summary Notes	Primary Health Care Summit Day One Sum
G	Ecology of Medicine ; Presentation shared by Dr. Trevor Hancock Green et al (2001). The Ecology of Medical Care Revisited *New England Journal of Medicine*	T Hancock slides.ppt NEJM 2001 Ecology of Medical Care Revisited