Evidence-led resuscitation of primary care: An Equity-guided Quadruple Aim Approach

Presented by

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Enhanced Equity & Access Quadruple Aim for Primary Health Care

Figure 1: Enhanced Equity & Access Quadruple Aim for Primary Health Care
Adapted by Dr. Emily Gard Marshall (2018) from Bodenheimer & Sinsky (2014)

Health Care Management Forum PC Special Edition: *"Better, not just bigger: Resuscitating sustainable and equitable primary care in Canada."*

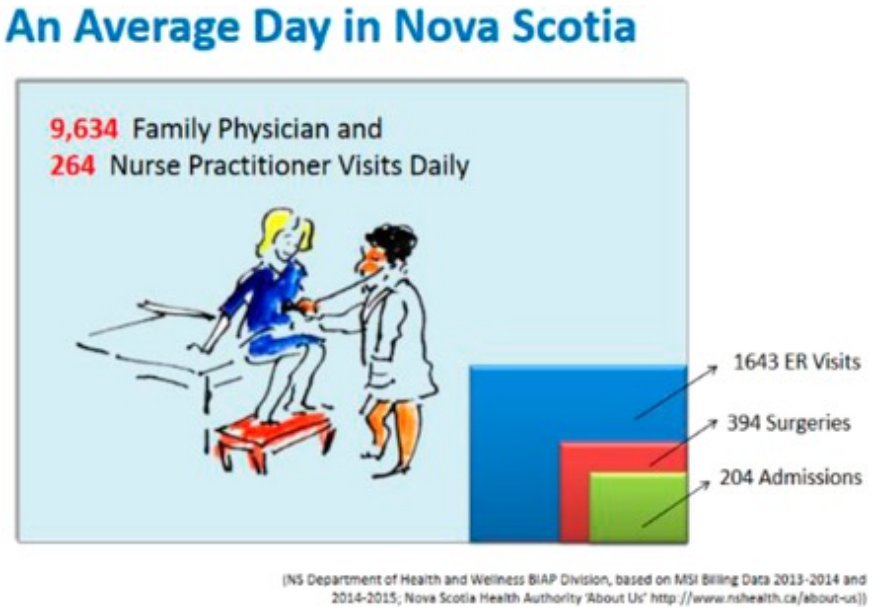
Articles in this special edition address challenges in primary care authors' diverse expertise and research, offering evidence-informed recommendations for policy and decision makers.

Themes:

(1)tackling equity in primary care;

(2)primary care models and strategies that work, and the rise of those that threaten our system; and

(3)building a sustainable and equitable primary care system.



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https://journals.sagepub.com/toc/hmfa/36/5

Key findings from the PUPPY Study (Problems coordinating and accessing primary care for Attached and Unattached Patients Exacerbated During the Covid-19 Pandemic Year)

- **Covid-19** created an environment where **primary care innovations pushed through without usual red tape**, including for UPs (e.g. Virtual care fee codes)
- **Asynchronous virtual care** modalities help patients access primary care, & need supports to implement and appropriate **remuneration, training, staffing, & funding**
- **Unattached patients** were far more likely to **use ED** for issues better addressed in PC than patients with PC attachment
- **Community pharmacists** play a crucial role in primary care, especially **unattached patients**; Both patients & pharmacists **want expansion of services** (scopes vary widely by province)
- **Complex & equity-deserving patients were disproportionately affected** during the pandemic. **Primary care nurses** manage patients' needs if available. Interdisciplinary primary care teams are essential for supporting complex patients.
- Health systems are managing a **pandemic backlog** in patient care and high acuity needs patients. We must consider how the **work can be distributed across allied health providers**
- **Attachment incentives** used to encourage taking on more patients **fail to address systemic challenges**
- An **increase in privately funded & delivered primary care grew during the pandemic** as patients get more desperate for access. However, **patients value publicly funded healthcare & DO NOT want to see the public health system eroded by industry-profit driven care**

MAAP: Addressing how little we know about primary care

The Models & Access Atlas of Primary care (MAAP) research began in Nova Scotia & replicated in four more provinces so far (NL, PEI, NS, BC, SK)

MAAP NS conducted census surveys with all primary care administrative staff, family physicians, and nurse practitioners with high response rates: Data were linked to administrative billing data for provider & patient outcomes

- Practice survey (receptionist) 85%RR
- FP/NP survey 60%RR

MAAP address knowledge gaps on:

- How primary care practices are structured
- What accessibility and comprehensiveness are like for patients
- Impact on patient care outcomes (survey data linked to administrative billing data)

These findings are necessary for evidence-based policy development & evaluation that addresses major gaps in primary care data. (Administrative data is inadequate)

Developing a National MAAP Study funding proposal

https://maap-bc.ca/

https://www.dal.ca/sites/maapstudy.html

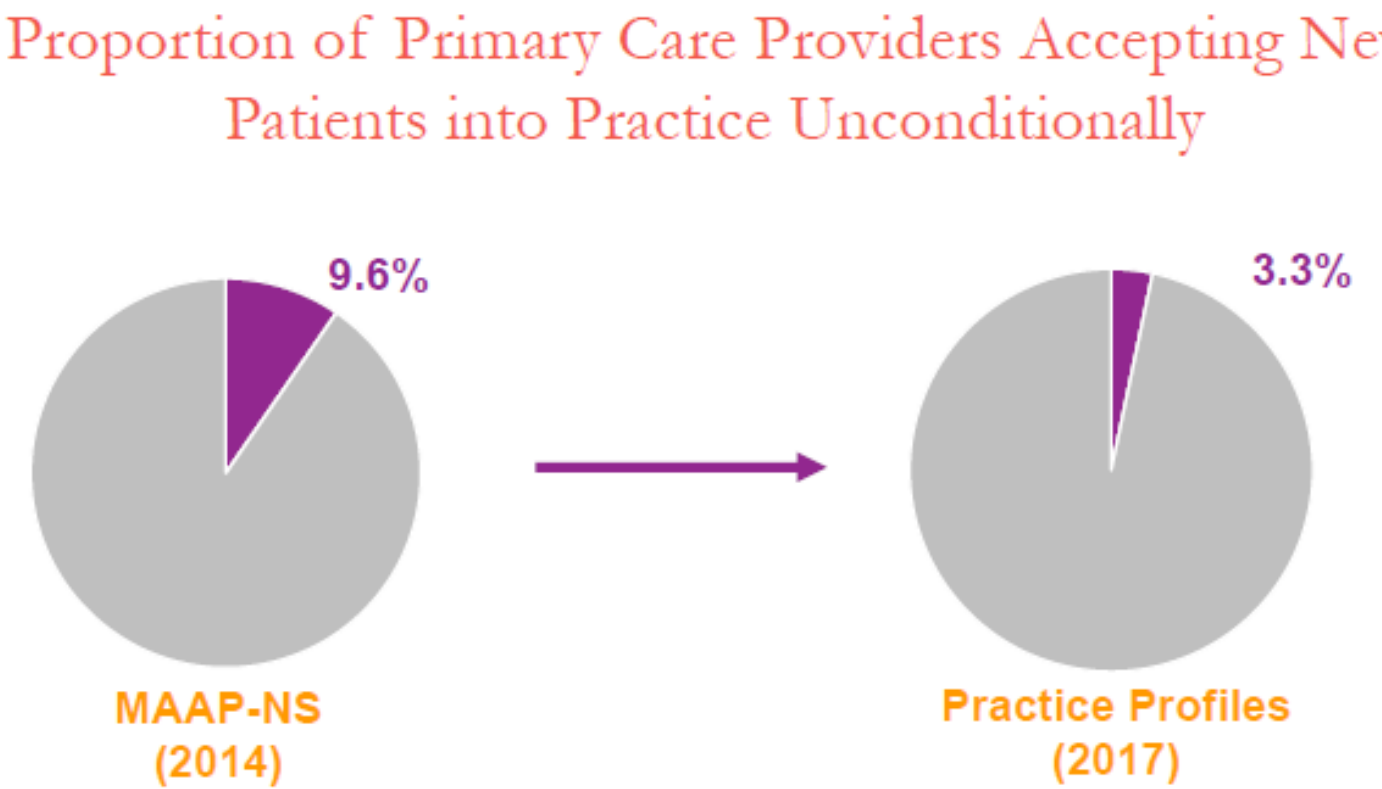
2014 (these issues aren't new)
Patient access to a regular PHC provide

- The proportion of Canadians without a primary care provider is rising
- In Nova Scotia, 58,046 people (~**10.28%** of NS) are currently on the "Need a Family Practice Registry"
- Unattached patients are more likely to:
    - Be young
    - Be male
    - Be recent immigrants
    - Have lower SES
    - Have fewer chronic conditions
    - Have severe mental illness
- MAAP-NS linked provider & billings data showed patients of providers soon to retire were **older & have more chronic conditions**

MAAP-NS Findings

- Less than **10%** of providers are **accepting** new patients **unconditionally** and **51%** will accept patients only under certain **conditions**
- **27.9%** of providers whose were reported by their receptionist to be accepting new patients, were reported to not take patients who **require narcotics/opioids**
- Only **20%** of providers who conditionally accept patients will take new patients who require **prenatal** care
- **47%** of providers who will accept new patients (either conditionally or unconditionally) conduct unbilled **"meet and greet"** appointments before accepting new patients into practice (Marshall et al. 2017, Family Practice)

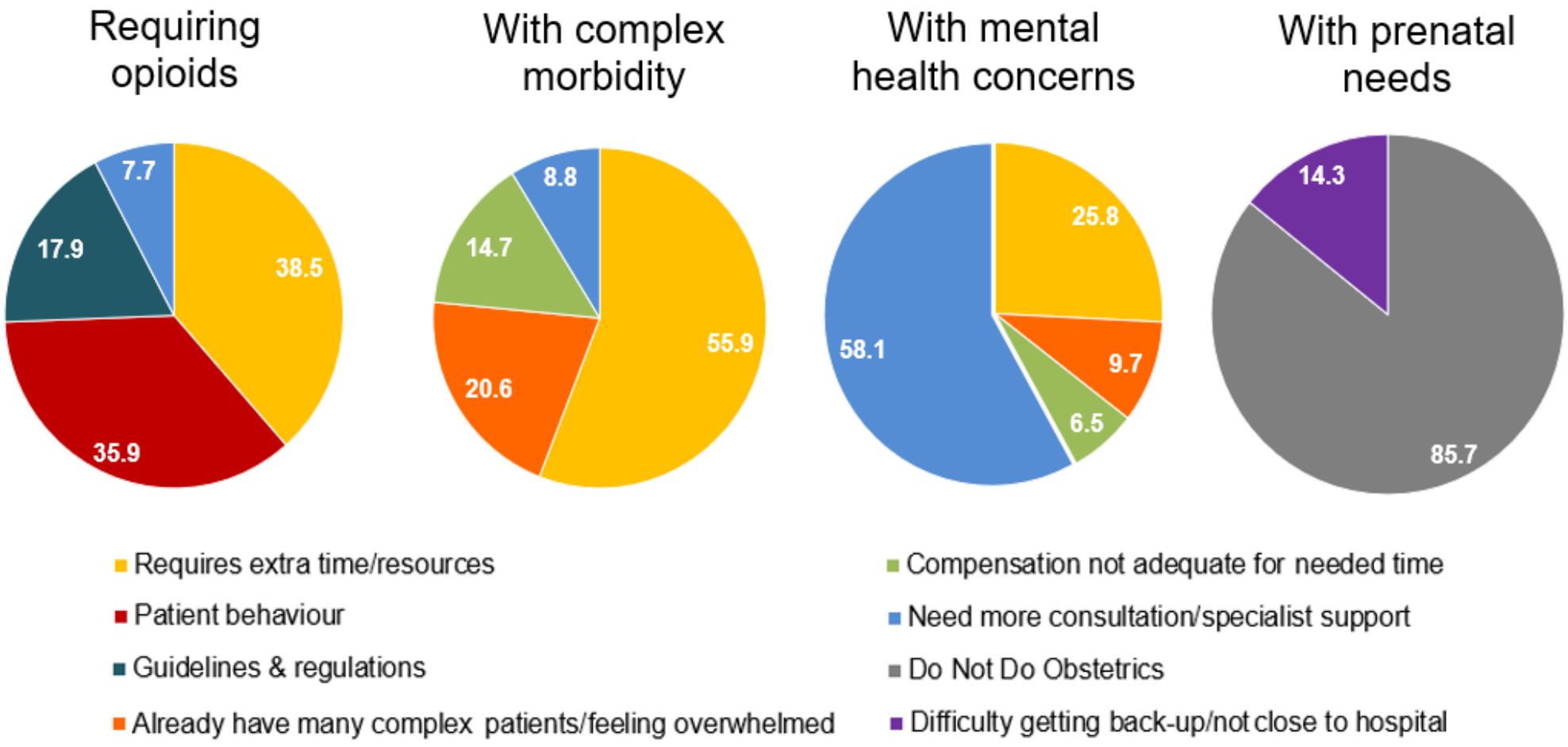
Results 2014- 2017



Most challenging patients for providers

Challenges to accepting new patients into practice

Provider identified challenges (%) associated with patients …



Suggestions from providers: What can be done

Suggestion	% of responders
More mental health services support • more professionals in community • better access to services	32%
Changes in payment • changes to fee codes to reflect needs and time required • fund nurses • fund teams • increase fees for house calls • blended compensation model • rostering system of payment	28%
Collaborative teams needed	24%

Suggestions from providers: What can be done

Suggestion	% of responders
More family doctors	7%
More time for each patient	6%
More education • CMEs • health educators to help patients prepare for visits & take responsibility for their own health • make patients aware of what's available	6%

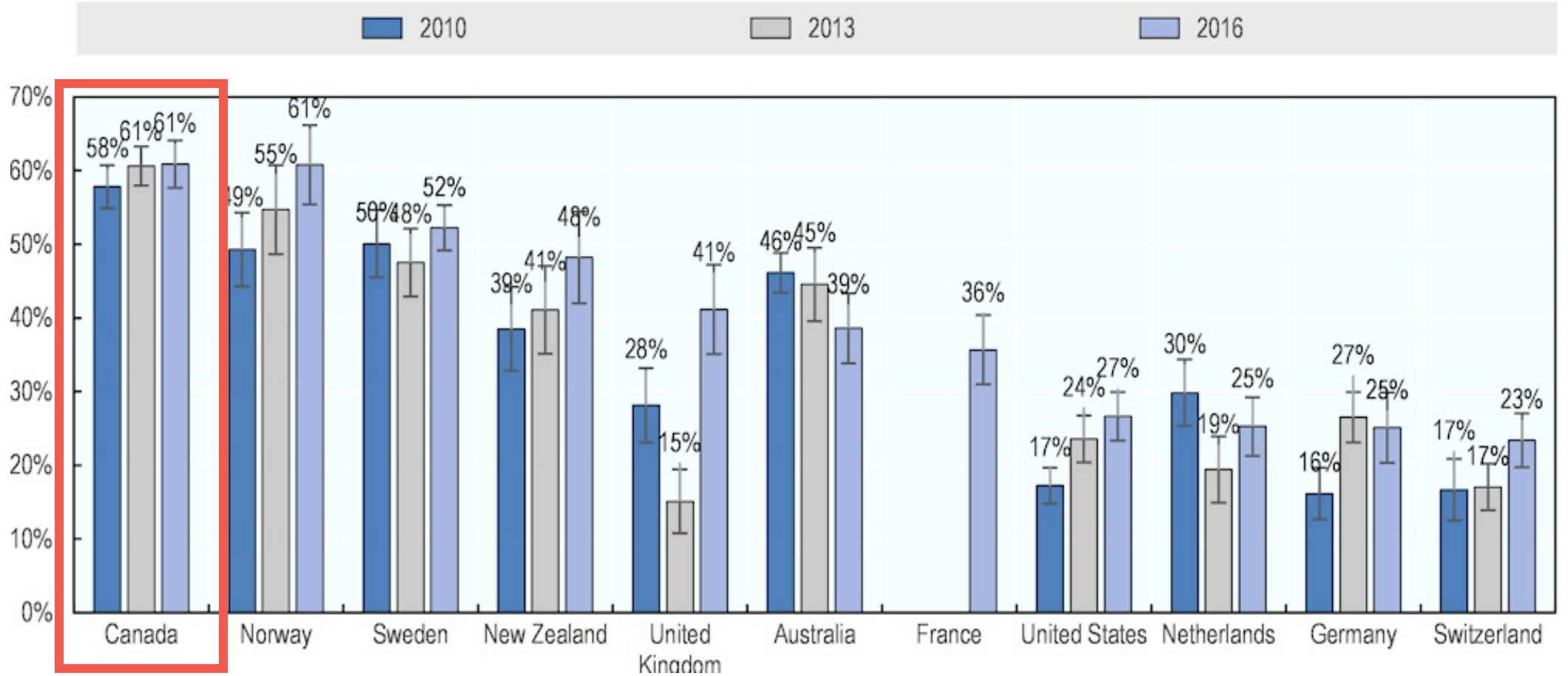
Conclusions

Given family physicians' **autonomy** in accepting patients, there is a genuine need to **assist providers** in their capacity to help challenging patients:

- Ensure the most vulnerable patients have access to comprehensive primary care
- To reduce the likelihood of discriminatory access
- Have family physicians feel good about their work at the end of the day

MAAP: Wait times for specialist care 2018

The share of people waiting one month or more for a specialist appointment is two-times greater in some countries than in others, with Canada being the longest



Source: OECD calculations based on 2013 and 2016 Commonwealth Fund International Health Policy Surveys. https://www.oecd-ilibrary.org/sites/242e3c8c-en/1/3/2/index.html?itemId=/content/publication/242e3c8c-en&_csp_=e90031be7ce6b03025f09a0c506286b0&itemIGO=oecd&itemContentType=book

Results: Themes from Providers

How do wait times for specialists affect the way you practice?

- Pervasiveness of long wait times
- Providers experience burnout
- Managing beyond scope
- Consequences for patients
- Scheduling repeat visits/reduced capacity
- Managing patient expectations
- Additional work in strategizing & referring

Results: Themes from Providers

Recommendations

- PCP follow-up & interim care while awaiting specialist
- Better pay for complex patients (research & management time)
- More specialist providers to meet needs
- Investment in e-solutions
- Referral acknowledgements from specialists
- Equity, challenge: patients who can travel get more options; & PCP report referring patients to private system

Most challenging patients & how we could do better

Primary care is in crisis:

- Need to invest in team-based care, so patients get the right care at the right time, from the right provider
- Need to ensure primary care providers have the supports they need to work to the top of their scope
- Shift funding models away from traditional fee-for-service models (it's what new grads are looking for)
- Leverage technology to provide options for patient access to primary care, e.g. video, telephone, and asynchronous modalities to support patient access
- Primary care providers need skilled administrative staff & access to specialists & laboratory and diagnostic services to manage their patients

How can we build sustainable equitable primary care in Canada?

If everyone has to think outside the box, perhaps the box is the problem.

- Innovations have been implemented in the short term to improve access to primary care as a “band-aid” solution to systemic problems; & while band-aids may be necessary, they are not long-term solutions.
- Election cycles should not be the main impetus for improvement.
- Progress in primary care may include advancing scope of practice, particularly across professions (e.g. nurse practitioners, nurses, pharmacists, social workers, physician assistants, & other allied health professionals).
- To sustain equitable access & our publicly funded primary care system, we must battle against for-profit healthcare in Canada.
- As we move towards a bigger & better primary care system in Canada, it behooves us to also consider our impact on other nations, some of which we actively recruit providers from. If the pandemic taught us anything, it is that we are a global community, & our health is inextricably linked to the health of all of humanity. We have both the ability & responsibility to support equity in access to care within & beyond Canada.

PHC Innovations to Improve Access in Nova Scotia

The COVID-19 pandemic created an environment where primary care innovations could be pushed through without the usual red tape. Innovations were introduced to support patients who might otherwise fall through the cracks (e.g., unattached patients).

“We didn’t let perfection be the enemy of the good”

- NSH Primary Health Care Strategy and a Chronic Disease Management and Wellness Strategy; prioritizing access and attachment
- Updated the Strengthening the Primary Health Care for 2023 context - an evidence synthesis and guiding document for primary care delivery
- Practice Support Programs - for providers; the zones are hiring Practice Facilitators to work directly with practices to improve access and streamline processes (e.g. EMR optimization)
- The Need a Family Practice Registry is now prioritizing/triaging (through the gathering of health information needs)
- The number of collaborative family practice teams & Primary Care Clinics are increasing within Nova Scotia
- Patients can now access PHC through Community Pharmacy Primary Care Clinics & Pharmacy Plus Clinics, Virtual Care Nova Scotia, 811, Urgent Care Clinics, Mobile Primary Care Clinics, and Primary Care Clinics - increases access at the community level
- Increasing after-hours access in many areas
- Electronic referral forms to specialists coordinated through a central access point used by primary care providers
- NSH website leads you to the information for accessing PHC
- Patient education material developed & promoted - Where to Go for Health Care by geographic areas
- A public facing dashboard that details the Need a Family Registry and number of patients accessing the various PHC services More information is available internally to decision makers to inform planning (Tableau)
- 'Your Health NS' app to make it easier to book appointments, access vaccine records, obtain health information
- Work recently completed on PHC Metrics - to help inform CFPT composition based on geography, how hard it is to recruit to the area, & patient demographics (age, gender, level of social deprivation)
- Community Health Teams - virtual & in-person classes cover topic areas like self-management, health coaching, healthy eating, mental wellness, physical activity, parenting, and managing risk factors - Register for Online Wellness Programs - HealthyNS - LibGuides at Nova Scotia Health (nshealth.ca); these are preventative programs aimed at improving wellness and subsequently decreasing demands on other areas within the health system
- Patient Family Advisors are involved in many different PHC initiatives
- The DCPNS Registry is an information system containing data on demographics, diabetes type, treatment, & self-management - information used to identify trends and opportunities to improve processes/care

Questions are welcome!

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