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en santé du Canada

CIHR PRIMARY HEALTHCARE SUMMIT

Patient-Oriented Primary Healthcare - Scaling Up Innovation

**January 18 and 19, 2010
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Main Messages

Primary healthcare is the foundation of Canada's healthcare system. It is viewed as the gateway or first point of contact with the healthcare system for all Canadians, who receive a diverse and comprehensive array of services in primary healthcare. The key attributes of a strong primary healthcare system include coordination of care, including an electronic medical records system; long term person focused care; comprehensiveness; and chronic disease prevention and management.

A strong primary healthcare system is vital to health. Strong primary healthcare is linked to better health outcomes, improved equity, and an improved patient experience, and is recognized as the foundational basis for a high-performing, accessible, and sustainable healthcare system. Robust primary healthcare systems are also recognized as contributing to improved access to healthcare, reduced inequities, lower health system costs, improved outcomes, and higher patient and provider satisfaction.

A strong primary healthcare system is also cost-effective. An effective primary healthcare system is also the key to delivering high quality care and improving healthcare outcomes in a cost-effective way by reducing health system costs – a key challenge for many cash-strapped provincial governments.

Canada's primary healthcare system is lagging behind those in other developed countries. Canada has not yet achieved a robust primary healthcare system that provides patient-centred, comprehensive and coordinated primary healthcare, and lags behind several other developed countries in terms of access, quality improvement and management, and the use of electronic medical records. Major primary healthcare issues in Canada include uneven access, fragmentation across the system, lack of communication and information sharing, insufficient use of inter-professional healthcare providers, inadequate chronic disease prevention and management, limited patient involvement and a misalignment of incentives in remuneration models.

Primary healthcare research in Canada is also lagging behind. Comparable nations have also done better than Canada in terms of investments in primary care research and in the translation of research knowledge to practice and policy. Again, Canada is lagging, both in terms of support for and coordination and translation of primary healthcare research. Primary healthcare researchers are isolated, data are difficult to access, and there is limited, meaningful coordination between governments, institutions and researchers. Moreover, local, innovative demonstration projects are not "scaled up."

The path forward for primary healthcare in Canada requires a clear vision. Primary healthcare is an area in critical need of innovative research and transformation. The path forward requires scaling up of innovation. We need collaboration and information sharing among all stakeholders; a patient-centred approach to care; primary healthcare champions at all levels of the system working together; scaling up of primary healthcare research and research support; and a clear vision for the path forward. This will require a three-pronged approach involving research, capacity and infrastructure. Coordinated investment to build a high-quality, skilled and innovative primary healthcare research community in Canada is needed. Probing, pertinent research questions must be asked. Investment in research, knowledge translation, capacity building and infrastructure will help to ensure that the issues discussed at this Summit are addressed and that future challenges are anticipated.

The vision for primary healthcare is for every Canadian to have access to comprehensive, high-quality primary healthcare. It is hoped that by 2020, Canada will be an international leader in the generation of high quality primary healthcare research that will contribute to a high quality primary healthcare system for Canadians.



Executive Summary

What is Primary Healthcare?

Primary healthcare is the face of the Canadian healthcare system. It is viewed as the gateway or first point of contact with the healthcare system for all Canadians, who receive a diverse and comprehensive array of services in primary healthcare, including prevention, prenatal care, episodic care, chronic disease management, mental health care, post-hospitalization follow up, and rehabilitation. The key attributes of a strong primary healthcare system include coordination of care, including an electronic medical records system; long term person focused care; comprehensiveness; and chronic disease prevention and management.

Why is it Important?

A strong primary healthcare system is vitally important. Strong primary healthcare is linked to better health outcomes, improved equity, and an improved patient experience, and is recognized as the foundational basis for a high-performing, accessible, and sustainable healthcare system. Such systems are also recognized as contributing to improved access to healthcare, reduced inequities, lower health system costs, improved outcomes, and higher patient and provider satisfaction. Indeed, the definitional principles of primary healthcare include accessibility, comprehensiveness, continuity and appropriateness. An effective primary healthcare system is also the key to delivering high quality care and improving healthcare outcomes in a cost-effective way by reducing health system costs – a key challenge for many provincial governments which are now looking at the prospect over the next few years of spending nearly 50% of public expenditures on the healthcare system.

The Current State of Primary Healthcare and Research in Canada

Despite the recognized contributions that high quality primary healthcare can make to health and health systems, Canada's primary healthcare system is in need of help. Canada has not yet achieved a robust primary healthcare system that provides patient-centred, comprehensive and coordinated primary healthcare, and lags behind several other developed countries in terms of access, quality improvement and management, and the use of electronic medical records. Major primary healthcare issues in Canada include uneven access, fragmentation across the system, lack of communication and information sharing, insufficient use of inter-professional healthcare providers, inadequate chronic disease prevention and management, limited patient involvement and a misalignment of incentives in remuneration models.

Currently, primary healthcare research in Canada mirrors the primary healthcare system itself: uncoordinated and in need of transformation and renewal. Again, Canada is lagging, both in terms of support for, and coordination and translation of primary healthcare research. Primary healthcare researchers are isolated, data are difficult to access, and there is limited, meaningful coordination between governments, institutions and researchers. Moreover, local, innovative demonstration projects are not "scaled up."

The Vision for Primary Healthcare

Despite the current state of primary healthcare and primary healthcare research in Canada, the vision is for every Canadian to have access to comprehensive, high-quality primary healthcare. It is hoped that by 2020, Canada will be an international leader in the generation of high quality primary healthcare research that will contribute to a high quality primary healthcare system for Canadians. The design, implementation and timely translation of high quality research results will be available to all primary healthcare stakeholders. A broad range of multi-method research and



knowledge translation activities will be delivered by a network of highly trained clinician investigators, research scientists and knowledge users, all of whom will be supported by a dedicated research infrastructure. Close connections among researchers, clinicians, policy makers and other stakeholders will ensure that the outputs of the strategy are relevant and responsive to changing community needs.

A Move Towards a Robust Primary Healthcare System in Canada

As discussed at the Summit, it is finally time for primary healthcare. Canadians demand and deserve high-quality care, delivered in the right environment and by the right provider. Primary healthcare is an area in critical need of innovative research and transformation. The path forward requires scaling up of innovation. We need collaboration and information sharing among all stakeholders; a patient-centred approach to care; primary healthcare champions at all levels of the system working together; scaling up of primary healthcare research and research support; and a clear vision for the path forward. This will require a three-pronged approach involving research, capacity and infrastructure. Coordinated investment to build a high-quality, skilled and innovative primary healthcare research community in Canada is needed. Probing, pertinent research questions must be asked. Canada must also develop the capacity to become internationally-recognized in primary healthcare research, and infrastructure support is needed to foster excellence, optimal collaboration, data sharing and the uptake of results across Canada. Investment in research, knowledge translation, capacity building and infrastructure will help to ensure that the issues discussed at the Summit are addressed and future challenges are anticipated before negative consequences arise.

Outcome of the Summit

The two day Summit brought together primary healthcare researchers, research funders, primary healthcare providers, CEOs, senior leaders and board members of healthcare delivery organizations and regional health authorities, decision makers at the provincial and federal levels, leaders from professional and advocacy organizations, thought leaders in primary healthcare and primary healthcare research, and representatives from national and provincial health organizations and agencies. National and international attention was focused on the issue of primary healthcare reform. The Summit enabled participants to gain a better understanding of the diversity of primary healthcare research in Canadian and international jurisdictions; engage in dialogue regarding innovation in patient-centric models for chronic disease prevention and management; understand existing barriers and explore solutions for achieving a high performing primary healthcare delivery system; and engage with Canadian and international leaders to explore innovative delivery models that can be applied in the Canadian context.

The Summit included plenary talks and panel discussions featuring nationally and internationally renowned speakers who spoke on a variety of primary healthcare topics. Workshops explored in-depth issues raised in the plenary sessions. Significantly, the Summit began with a discussion of individual patient's experiences in the primary healthcare system, highlighting the importance of patient-centred care. The key attributes of primary healthcare and the benefits they provide were shared. Issues around the implementation of chronic disease management models in England and the United States were discussed, including a focus on the factors that led to their respective successes. The reasons for Canada's failure in this area were also explained. The conceptual divide between patient-centered and guideline-driven care was explored, and the quality of some guidelines questioned. The appropriateness of using guidelines in some situations and not others was reviewed, and the risks of applying disease-specific guidelines to patients with co-morbid conditions were highlighted. The elements of primary care important to consider when evaluating performance were also discussed. The importance of aligning provider incentives with health system goals was highlighted. The reasons why Canada is lagging behind in the area of primary healthcare were also candidly discussed. An exploration of the linkages between public health and



primary care was given, including a description of the benefits and challenges of community-oriented primary care. The challenges surrounding the functioning of primary care practitioner teams, solutions for enhanced performance, and methods of team evaluation were also shared. One panel discussed the realities of collaborative teamwork, including the challenges and barriers to collaboration. The experience at Kaiser Permanente of the environment and processes required to successfully implement new technology into primary healthcare practices was also shared. The Summit concluded with frank discussions with the Deputy Minister of Health (Saskatchewan) and the Assistant Deputy Minister for Health Human Resources, Ministry of Health and Long-Term Care (Ontario), who synthesized the major themes of the Summit and offered suggestions on ways to achieve successful change and system-wide improvements in primary healthcare.

The plenary talks, panel discussions and workshops were very well received by participants. The vast majority of participants who completed the post-Summit evaluation form felt that the Summit achieved its goals and provided them with new knowledge and ideas that would help them with their work in their respective fields.

This Summit has succeeded in its vision and goal of fostering multidisciplinary collaboration among primary healthcare stakeholders and catalyzing new collaborations and innovative thinking in patient-centered delivery models in Canadian primary healthcare settings, primary healthcare research, knowledge translation and system transformation. The Summit also provided Canadian and international stakeholders with an opportunity to exchange best practices in implementing primary healthcare initiatives, and reinvigorated discussion and innovation on primary healthcare research and system transformation reform. May this collaboration and sharing of ideas continue.



Moving Forward

The CIHR Primary Healthcare Summit produced many useful recommendations and action items to improve primary healthcare and primary healthcare research in Canada, including:

1. **Create an electronic medical records system (and train healthcare providers to use it) to improve communication, information sharing and coordination of care.** This would avoid duplication and wasted efforts that currently result from a lack of computerized records. An electronic medical records system should support patients and providers by allowing instant access to medical records for physicians and patients, providing standardized data and linkages across data sets, and providing clinical content such as decision-support tools that enhance quality and patient safety, including drug interaction and allergy alerts.
2. **Educate primary healthcare providers and policy makers on the importance of providing a patient-centred approach to care.** All processes must be examined through a value lens as defined by the patient, and the best interests of patients must be the primary driver of policy decisions, priority setting and resource allocation decisions. This could include using a persona as a starting point to improve patient flow and coordination.
3. **Develop a chronic disease management model to improve chronic disease prevention and management in primary healthcare.** The model should include community resources, decision support tools, case and disease management, supported self care, the promotion of better health, and social care. Such a model should also include financial incentives to improve the quality of chronic care.
4. **Encourage patients to make better use of self care support through information support.** This includes educating primary healthcare professionals to provide better self care support through changed behaviors and treating self care as a priority. In Ontario, the Ontario Patient Self Management Network could take on this task with the creation of a mandate and the provision of funding.
5. **Educate physicians about the appropriate use of guidelines.** The use of guideline-based care is certainly appropriate in some circumstances; however, it is also highly inappropriate in others. As guidelines are not appropriate for all populations and individuals, physicians should be educated to use guidelines in combination with expert opinion, patient values and circumstances.
6. **Improve Aboriginal primary healthcare and decrease health inequities.** In doing so the challenges to indigenous wellness, Aboriginal determinants of health and Aboriginal health solutions must all be taken into account. Efforts to reduce the health inequities of Aboriginal peoples must involve the engagement of indigenous communities by the mainstream, including researchers, health professionals and decision-makers.
7. **Develop and implement a rigorous and quality primary healthcare evaluation for primary healthcare team functioning.** One example of an emerging issue resulting from a current lack of teamwork is the opening of a private clinic in Winnipeg staffed by nurse practitioners. If team functioning is found to impact positively on outcomes, collaboration with inter-professional healthcare providers in primary healthcare should be increased and strengthened.
8. **Improve performance measurement of primary healthcare.** Care providers and policy and decision-makers need high-quality information to aid in decision-making, resource allocation, and to mobilize efforts for improvement. As many dimensions as possible must



be measured, else the performance picture will be incomplete.

9. **Align incentives in remuneration models with health system goals and remove reimbursements and incentives with perverse outcomes.** This could include reconfiguring the fee for service model and making a percentage of primary healthcare providers' income contingent on performance. Physicians could also be rewarded for coordinated care and quality versus quantity. Any such incentive system would need to be flexible and evaluated for future improvement.

10. **Invest in a high-quality, skilled and innovative primary healthcare research community in Canada.** Investment in research, knowledge translation, capacity building and a dedicated research infrastructure to support clinician investigators, research scientists and knowledge users is needed. Universities and healthcare institutions also need to step up efforts to recruit and retain high level researchers. Increased support for and coordination and translation of innovative primary healthcare research is also required, including better communication and more meaningful coordination and collaboration between governments, institutions and primary healthcare researchers, as well as processes to "scale up" innovative demonstration projects.



CIHR Primary Healthcare Summit

Day 1: Monday January 18, 2010

Opening Remarks: CIHR in Primary Healthcare

Featuring: President Dr. Alain Beaudet, Dr. Colleen Flood

Canada's Primary Healthcare Weaknesses, Needs, and the Way Forward

Dr. Alain Beaudet, President of CIHR, began by questioning how research can improve the quality and accessibility of primary healthcare for Canadians. He emphasized that despite the fact that primary healthcare is the foundation of a high quality, accessible and cost-effective system, Canada has lagged behind many other countries in its attention to primary healthcare, which is long overdue. He highlighted the need to develop probing, pertinent research questions and create an innovative primary healthcare research structure, and for universities and healthcare institutions to step up efforts to recruit and retain high level researchers. He stated that progress would be made if we could identify key milestones to set Canada on the right track, and expressed his hope that the CIHR Primary Healthcare Summit would act as a catalyst to increase research in primary healthcare.

Dr. Colleen Flood, Scientific Director of CIHR, emphasized that Canada's primary healthcare system and primary healthcare research both have room for improvement. Canada does not yet have a robust primary healthcare system that provides patient-centred, comprehensive and coordinated care. Canada lags behind several other developed countries in terms of access, quality improvement and management, the use of electronic medical records, and support for, coordination and translation of primary healthcare research. Primary healthcare researchers are isolated, data are difficult to access, and there is limited, meaningful coordination between governments, institutions and researchers. Canada is also ripe with innovative, local demonstration projects that are not "scaled up," and there are no processes in place to scale up innovation. Looking forward, advancing primary healthcare will require a collective commitment to scaling up innovation. This will require collaboration and information sharing among all stakeholders; a patient-centred approach to care; primary healthcare champions at all levels of the system working together; the scaling up of primary healthcare research and research support; and a clear vision for the path forward.

The Future of Primary Healthcare Research in Canada

Dr. Flood anticipated that in terms of the future of primary healthcare research, the vision is that by 2020 Canada will be an international leader in the generation of high quality primary healthcare research that will contribute to a high quality primary healthcare system for Canadians. Moreover, the design, implementation and timely translation of high quality research results will be available to all primary healthcare stakeholders. To reach this goal, a three pronged approach will be required, encompassing the funding of high-quality, relevant primary healthcare research and knowledge translation; the development of the capacity to become internationally-recognized in primary healthcare research; and supporting infrastructure to foster excellence, optimal collaboration, data sharing and the uptake of results across Canada. Dr. Flood emphasized that the Summit's vision and goal is to foster collaboration among primary healthcare stakeholders and to catalyze innovative thinking in primary healthcare research, knowledge translation and system transformation.



Plenary 1 – Primary Healthcare in Canada: Three Patients’ Perspectives

Featuring: Annie Akavak, Alli Calladine, Andrea Butcher-Milne

This session featured three patients and their experiences with primary healthcare in Canada.

Experiences as a Patient and Caregiver - Andrea Butcher-Milne

Andrea Butcher-Milne discussed her experiences as they related to her own healthcare and as a caregiver to both her mother and daughter. Andrea was diagnosed with multiple sclerosis and described the positive impact of the programs available from the Barrie Community Health Centre. It was later discovered that her daughter had ovarian tumors, and the care they received at Sick Kids was exemplary. Andrea is a very proud healthcare advocate, and feels that the care she has received from various sources has helped her form a sense of community, contributing to her positive experience.

Experiences as a Young Diabetic - Ali Calladine

Ali Calladine, a 14-year old Type I diabetic, described her interactions with the primary healthcare system. She recognized that proper diabetes management was her responsibility, but emphasized that with increased discussion and understanding, the healthcare system could aid her in managing her diabetes. She viewed primary healthcare as crucially important for diabetes, but described poor experiences with the primary healthcare system, even believing that her physician “didn’t know anything about diabetes”. She strongly emphasized the importance of physicians listening to the story of each patient, and proceeding with management and treatment accordingly.

Experiences as an Expectant Substance Abuser - Annie Akavak

Annie Akavak presented her experiences as an addicted pregnant woman going through the healthcare system. She felt that healthcare professionals were judgmental given her substance abuse problem and that her needs were not met. She suggested that there be specialized training for healthcare professionals working with expectant mothers with mental health and addiction issues, and a special place for them to be treated. Annie stated that since having received treatment for her addiction, she is able to speak up for herself and direct her own care.

An Overview of Primary Healthcare in Canada

Featuring: Dale McMurchy

Key Attributes of Primary Healthcare

Dale McMurchy provided a high-level overview of the state of primary healthcare in Canada. She listed the four key attributes to the delivery of primary healthcare as: coordination of care, including an electronic medical records system; long term person focused care; comprehensiveness; and chronic disease prevention and management. However, in Canada, only 25% of physicians use electronic medical records, and only 2% of Canadians have access to them.

Benefits of Coordination of Care and Long Term Person Focused Care

The benefits of coordination of care are many, including reduced duplication of services, greater patient satisfaction and compliance, saved consultation time, less hospitalization and emergency department use for ambulatory care-sensitive conditions, improved screening and immunization rates, improved chronic disease prevention and management, improved patient safety and lower costs. In addition, long term person focused care allows for more timely care, appropriate preventative care, a greater likelihood of health problems recognition, fewer diagnostic tests and prescriptions, more accurate diagnoses, lower costs, reduced emergency department and hospital use for ambulatory care sensitive conditions, and reduced health disparities associated with socio-economic status.



The Importance of Comprehensive of Care

With respect to comprehensiveness of care, primary healthcare practices that provide comprehensive and coordinated quality care confer the most benefit to patients. Generally, such practices have a sound knowledge of their patients and community, provide evidence-based care, provide collaborative team-based care, use and share electronic medical records, and have effective patient flow processes. The benefits of comprehensive care are also plentiful, including improved quality of care, increased prevention and screening activities, improved chronic disease management and markers, reduced morbidity and mortality, improved quality of life, reduced preventable hospitalizations, lower hospital readmission rates, reduced length of stay, reduced complications, reduced costs and improved patient knowledge and experience. In addition, the quality of care that is delivered is also very important, however Canada is only second to the United States for medical errors involving the wrong medication, treatment or lab test.

Key Issues in Primary Healthcare

McMurphy listed the key issues in primary healthcare to be rehabilitation, mental health and addiction, gender, children and youth, socio-economic status, Aboriginal peoples' health, rural health, and informal caregivers. In addition, Canada requires better lesbian, gay and transgendered care. There are also issues with respect to access to care, especially in rural areas, and care received by the most vulnerable. McMurphy emphasized the need for horizontal equity, providing care based on different patients' needs, and the importance of support for informal caregivers.

Implementation and Patient Outcomes

Plenary 2 – Implementing and Measuring a Chronic Disease Management Model: Experiences from the US and UK

Featuring: Dr. David Colin-Thomé, Michael Hindmarsh

The UK Perspective - Dr. David Colin-Thomé

Dr. David Colin-Thomé provided an overview of the challenges and solutions for the implementation of chronic disease and primary care programs in England. Chronic disease is a very large area of work, with the Department of Health's best estimate being that the treatment and care of those with chronic diseases accounts for 69% of the total health and social care costs in England. When outcomes were lagging, clinical leaders began producing national service frameworks. A new model called the NHS and Social Care Chronic Disease Management Model was created that drew on work by Wagner and Kaiser and used community resources, decision support tools, case and disease management, supported self care, and the promotion of better health. The inclusion of social care in the model signified that people with chronic conditions required a range of support that extended beyond the limits of the NHS. As a result, every general practitioner now has a computer, there is a push for electronic records, and general practitioners receive financial incentives to improve the quality of chronic care. Evidence has shown that the model is effective. National targets for patients having care plans and reduced emergency bed days for the chronically ill have been met.

In addition, a Combined Predictive Model was launched that predicts care needed for those with no previous hospital admissions. A Quality and Outcomes framework was developed as a part of the incentive scheme that goes beyond inputs and focuses on process, not just outcomes. Several factors have played a role in England's successful implementation of the chronic disease model. These include a national focus on population, prioritizing primary care, and creating incentives that involve patients in the assessment of health care. Future goals include a greater emphasis on self care and integration, universal case management for very high intensity users, requirements for multidisciplinary teams, personal health and care plans and assistive technology.



The American Perspective - Michael Hindmarsh

Michael Hindmarsh explained that the disease centred approach to disease management, despite being based on evidence, does not work within the primary care structure. A primary care model that works for all diseases was developed with productive interaction between prepared, proactive and practicing teams. When implemented, practices moved to planned population-based care and worked effectively as teams. It was found, however, that teams that implemented all processes of the model were more successful than teams that implemented only pieces of the model. Successful implementation of the Chronic Care Model involves working as teams, practices moving to proactive, planned, population-based care, self-management support at every encounter, levels of care delivery based on risk stratification, the use of clinical practice guidelines, leverage of community partnerships to enhance patient self care, and engaged leadership. This requires “epic whole practice re-imagination and redesign”, and dedicated time, not small changes. This is possible - for example, the Veteran’s Health Administration successfully underwent a complete system overhaul based on the Chronic Care Model. In addition, the Bureau of Primary Health Care, in charge of 850 federally funded health centres, mandated a year-long learning collaborative using the Chronic Care Model and was very successful in initiating transformation despite limited resources.

Similar efforts in Canada have begun in British Columbia and are moving eastward, but only in sporadic pockets of excellence and mostly in isolation from the government. Canada is lagging behind because of a lack of national focus, lack of performance measurement and accountability, lack of coordination of systems, and lack of a mandate or incentive to collaborate across the country. Moreover, disease-specific organizations promote a culture of siloed care such that care remains disease and procedure focused. The realization that primary healthcare must be the medical home for Canadians has yet to be embraced. Canada needs long-term policies that support fundamental system change and a recognition of primary healthcare as the central care coordinator for Canadians, a national perspective, reimbursement policies that recognize the different care system needed to deliver effective chronic care and prevention, removal of reimbursements and incentives with perverse outcomes, standardized performance measures and rewards based on quality versus quantity, increased translational research, clear accountabilities for Ministries involved in healthcare, a national program for quality improvement, rewards for coordinated care, provider accountability to engage in effective population-based care, and medical students trained toward a new system of care.

Plenary 3 – Maximizing Patient-Oriented Care: Does Adherence to Guidelines and Targets Maximize Patient Outcomes?

Featuring: Dee Mangin, Barbara Starfield

Sacred Monsters – Guidelines, Targets and the Nature of Good Care - Dee Mangin

The Discordance between Patient-Centred and Guideline-Driven Care

Dee Mangin explained how patient-centered and guideline-driven approaches to care may be conceptually discordant when patients’ values are incorporated into a care plan. Care providers may feel uneasy about choosing not to follow a guideline, even if clinical judgment deems it to be the best course of action for a particular patient. Additionally, if following care guidelines is deemed “good”, physicians may be punished for providing the best care to a patient when that care falls outside of the standard guideline. Alternatively, care providers may be rewarded for care that is measurable good – i.e. follows a guideline – but is poor from the patient perspective. The conceptual divide between patient-centered and guideline-driven care provides Canadian researchers with a unique opportunity to advance primary care research and delivery by adapting the best elements of both models, learning from examples internationally.



The Weaknesses of Guidelines

Studies suggest that not all guidelines really use the “best” evidence. Many guidelines are based on “C-level” evidence, evidence that is out of date, or evidence that has been commercially driven and thus overestimates benefits and underestimates risks. Additionally, research is generated in highly selective populations that are not necessarily reflective of those seen in primary healthcare. Some guidelines rely on intermediate outcomes or proxies, where links between the proxy and the true outcome of interest is limited or tenuous. Lastly, guidelines are frequently drafted by individuals in direct conflict of interest. The treating practitioner may also be in conflict by receiving incentives for following a guideline that may or may not be in the best interests of a particular patient.

Even when guidelines accurately summarize the most high-quality, current research evidence, avoiding bias and conflict of interest issues, they fail to account for providers’ clinical experience and patient values. Guidelines are also almost exclusively reductive: they cover a single specific disease in isolation from other co-morbidities or conditions, assuming standardized delivery and improved health outcomes. The implicit assumption is that patients experience diseases in isolation and will respond homogeneously to treatment.

Reasons for Non-Adherence to Guidelines

It is certainly appropriate to aim for 100% guideline adherence in certain situations, such as immunization and hand washing. In many cases however, and in particular in chronic disease management, 100% adherence may be harmful to patients. Real primary care patient populations are more heterogeneous and diverse than those included in clinical trials, such that a full 40% of presentations do not fit the criteria for any known diagnosis, and 40% have multiple co-morbid conditions. Applying disease-specific guidelines to a population with multiple co-morbid conditions and risk factors (i.e. treating each disease in isolation) results in polypharmacy with the risk of medicine interaction. Again, however, a physician following these disease-specific guidelines would be considered to have provided “the right care”. Polypharmacy in and of itself can be considered a chronic illness, resulting in serious adverse outcomes including hospitalization and death. Lastly, every individual should have the right to evidence-informed healthcare influenced by their own priorities and values. Choosing not to follow a recommended course is a fundamental right, and thus adherence to guidelines has the potential to undermine patient autonomy.

The Importance of Informed Consent

Mangin pointed out that by providing a specific treatment to a patient, we may be selecting another cause of death without that patient’s consent. For example, providing a medicine that reduces the rate of death from cardiovascular disease by 15% increases the risk that a patient will die from cancer instead. In current practice, patients are not informed about the latter half of this equation. However, providing inadequate information to a patient making a healthcare decision is fundamentally unethical.

The Appropriate Use of Guidelines

The use of guideline-based care is certainly appropriate in some circumstances; however, it is also highly inappropriate in others. In these circumstances, guidelines should be used – in combination with expert opinion, and patient values and circumstances – to support good care, not to drive it. We need to support evidence informed care, providing risks and options to providers and patients, but allowing the real and complex lives of the patients to play a role in decision-making.

Assessing the Adequacy of Primary Care: What Indicators? - Barbara Starfield

What is Primary Care?

Barbara Starfield explained that primary care is the provision of first contact, person-focused care over time. Care is comprehensive and coordinated. It is person-oriented, not disease oriented. This raises questions about why we take lessons on adequacy from specialty care, which is necessarily disease-focused. The measurement of quality of primary care has expanded to reflect



several new imperatives: disease with a multitude of interacting causes; co-morbidity; dangers posed by new technologies and medications; effects of health system and delivery characteristics (which cannot be accounted for using clinical trials); and issues of equity in health care.

The Benefits of Primary Care in Cases of High Morbidity

Resource use in a population is determined by the extent of co-morbidity, not by the presence or absence of particular diagnoses. According to the Johns Hopkins' Adjusted Clinical Groups system of classification, in more than two-thirds of the non-elderly population, co-morbidity is low. Among those with specific chronic conditions, however, rates of medium and high morbidity are higher, meaning that people who have one disease are much more likely to have more and more co-morbidity. Within a disease burden category, the specific type of disease does not generate different levels of use – it is the overall burden category that predicts level of usage. Thus, management-focused care based on individual diseases does not make sense for evaluating primary care. The benefits of primary care are greatest for those with a high morbidity burden, which is why application of the disease management model has not been useful in improving health in the context of primary care.

The Elements of Primary Care and Imperatives for Quality Assessment

The elements of primary care important to consider when evaluating performance can be classified according to Donabedian's Structure, Process and Outcome framework: capacity, performance, and health status. Capacity assesses system-level features that impact primary care performance. Performance measures assess the provision and receipt of care. There are seven elements of primary care that can be evaluated using this framework: first contact, longitudinality, comprehensiveness, coordination, family-centeredness, community orientation, and cultural competence. In addition, there are five imperatives for assessing quality in primary care:

1. The importance of patient-focused assessment, not disease-focused assessment;
2. The increasing danger of medical intervention;
3. The recognized effect of the mode of delivery of health services on health;
4. The explosion of interest in equity as an important outcome; and
5. Knowledge generation for population-based evidence.

The Problems with Disease-Oriented Technical Quality

Disease-oriented technical quality is not useful for primary care for two reasons. First, co- and multi-morbidity are characteristics of primary care, and second, guidelines are not appropriate for all populations and individuals. There are also statistical issues with measuring disease oriented technical quality, namely fewer than 10% of physician groups have patient samples large enough to reliably assess a 10% difference in technical quality. To be useful, technical measures must be aggregated into measures of quality across disease, based on delivery characteristics, and assess functional outcomes over time (while adjusting for case-mix).

Panel 1 – Are We Implementing Evidence-Based Care with a Focus on the Patient?

Featuring: Philip Sherman, Michael Hindmarsh, Dr. Colin-Thomé, Dee Margin, Barbara Starfield

Strategies for Effective Primary Healthcare

Participants asked the panel about various strategies to achieve effective primary healthcare services and the unintended consequences of existing models of care. The importance of aligning provider incentives with health system goals was highlighted by Dr. Colin-Thomé and Michael Hindmarsh. Dr. Colin-Thomé advised that healthcare practice can be changed with incentives by using direct pay-for-performance, and gave as an example a UK program where 15% of physician salary is based on performance. Hindmarsh emphasized that it is not always best to pay physicians



to do things because then they will do those things without attention to adverse effects or appropriateness of care. Incentive systems must be flexible and evaluated for future improvement.

The Role of Research in Primary Healthcare

When asked about the role of research to support primary healthcare, Starfield commented that its role is to ask the right questions. Mangin stated that research is important for informing new models of care and evaluating them. Research can also inform cost-effectiveness, which can then be used by group saving to enhance their services.

Integration of Services and Cost-Effectiveness

When asked about the integration of services across primary, secondary and tertiary care, the essential need to integrate care across settings was emphasized by all. Participants also asked about the difficulties associated with conducting cost-effectiveness studies on primary healthcare interventions and the need to demonstrate this when communicating with policymakers. Dr. Colin-Thomé advised that primary healthcare does cost less, although it still has to improve. Starfield stated that there is lots of evidence for the cost-effectiveness of primary healthcare.

Strategies in Other Jurisdictions

When asked what other jurisdictions are doing to integrate healthcare with social care, Hindmarsh stated that family health teams co-locate health and social care professionals which facilitate addressing social determinants of health. To encourage health professionals to work in primary healthcare and in teams, Mangin suggested the budget holding model, for if physicians are given control over the budget, they will work to maximize it for the population for which they are responsible. When asked what lessons have been learned about improving care for marginalized populations, Dr. Colin-Thomé stated that although a universal health system helps, maldistribution of services remains a challenge.

Canada's Primary Healthcare Barriers and the Way Forward

Panel 2 – So What's with Canada? Why Are We Lagging Internationally? What Are the Political Barriers to Implementing Change?

Featuring: Maureen O'Neil, Elinor Caplan, Doug Stich, Michael Rachlis, Rob Wedel

Why is Canada Lagging Behind? - Elinor Caplan

In Canada, health is within provincial jurisdiction; the federal government is a passive funding partner. There is an assumption that changes in the healthcare system will be bad, and change is especially difficult when income may be affected. Provincial governments negotiate changes with medical associations, who act as unions, within an environment of fear and lack of trust. Caplan reviewed provincial attempts at cooperation with medical associations, some of which have met with some success. Ontario, however, has not met with success in negotiating with the OMA. Provincial governments can only implement primary healthcare changes by legislation and regulation, funding models that require negotiations, persuasion and exposure, and public support and understanding. The guiding principle of the OMA's negotiating position with all governments has been and remains no accountability or transparency, no formula or agreement that rewards outcomes or results, no performance monitoring, and the domination of fee for service. As a result, the government must pay more for every change, and Canadians are paying more and getting less because incentives are perverse to the outcomes that patients want, need, and expect. Caplan emphasized the need to focus on quality, evidence and outcomes, stating that quality care should cost less. Primary healthcare reform is an important first step to system development.



Doug Stich

Stich provided an analogy for the recent evolution of the primary care physician: A short order cook whose restaurant grows so that he needs to hire multiple sous-chefs, diversify the menu and coordinate the functioning of a massive professional kitchen, when all he really wanted to do was cook. Outside of healthcare this sort of transformation happens all the time, requiring reinvestment, diversification, and change training.

Dr. Rob Wedel

Dr. Wedel noted that in the last ten years, Canada was in the middle of the pack in terms of primary healthcare, but is now lagging. However, Dr. Wedel does not view Canada as a “lagger”, just a late bloomer, as the evidentiary vacuum is filling fast. At present, we consistently duplicate and waste efforts due to a lack of computerized records. Canada needs to organize in such a way so as to use its supports properly.

Why Does Canada’s Primary Healthcare Lag Other Countries? – Michael Rachlis

Rachlis discussed how Canada arrived at its current situation with respect to primary healthcare. The original vision for Medicare came from Swift Current, Saskatchewan in 1945. However, Saskatchewan physicians in the 1950s wanted independent practice and did not want to negotiate with regional authorities. Ultimately, 90% of doctors went on strike when the province legislated public insurance in 1962. Although a 1972 Report recommended re-organizing the system using a Swift Current type of model, it was mainly ignored because of opposition from provincial medical associations. Some new models were established and were successful, but they did not spread.

Rachlis discussed some of the barriers to better primary healthcare, including the fact that provincial governments negotiate their primary healthcare policies behind closed doors with provincial medical associations which have until recently been dominated by specialists. In addition, evidence has been kept out, and the resulting institutions and organizations mainly have not worked. In terms of where to go from here, Rachlis recommended the reform of private practice and better use of evaluation.

The panelists discussed the issues in Canada’s primary healthcare system, one major issue being that negotiation between medical organizations and provincial ministries of health dominate how care is organized, delivered and paid for. These negotiations however take place in a climate of fear and mistrust. To fix the system, we need transparency and accountability; a restructuring of the system; new skills around team practice; a recognition from both physicians and government that practice management is a separate skill-set/job from treating patients and that it needs to be accorded proper time, energy and pay; and we need to get negotiations between the government and medical organizations out from behind closed doors so that both can be held accountable.

Day 2: Tuesday January 19, 2010

The Importance of Intersectoral Multidisciplinary Teamwork

Plenary 4 – Community-Focused Primary Healthcare

Featuring: Vivek Goel

What is Community-Oriented Primary Care?

Vivek Goel discussed the linkages between public health and primary healthcare. Though various definitions and terms have been coined to describe community-oriented primary care (COPC), it can be considered a strategic and systematic approach to primary healthcare using coordinated management by a primary healthcare team of public health and clinical professionals. The original COPC model was developed by Kark in the 1950’s, who developed a community practice in Africa based on healthcare not only occurring in the community and for a community but with the



community; multidisciplinary teams; and innovations with respect to needs assessment, monitoring, evaluation, and research. COPC has evolved since the 1978 WHO/UNICEF endorsement regarding the importance of primary healthcare, but there are still debates with respect to its value and cost-effectiveness.

When conceptualizing COPC it is important to consider that “community” does not have to be geographically bound. Although early applications tended to focus on underserved communities, it can be applied to any defined population. A shift in orientation is required from the individual patient/provider and healthcare institution to the practice of community health in order to be successful.

The Benefits of Community-Oriented Primary Care

The benefits of collaborating around COPCs include improved population health approaches, health service delivery improvements, improved team functioning, improved use of educational materials, and improved health outcomes. There are however barriers to collaboration, which include language, culture and training differences, lack of resources, lack of provider incentives, lack of support for team development, lack of time, lack of structure alignment, and definitional issues. Moreover, despite training programs, there is little evidence of COPC practices or of integration between primary care and community medicine. Systematic reviews of COPCs have also pointed to challenges to the COPC model including a lack of predictable reimbursement, difficulties encountered in incorporating COPC into training programs, a lack of understanding of the concepts, and a lack of infrastructure to enable COPC. With respect to research, there is insufficient ‘real-life’ evidence and evaluation to state that COPC is effective.

How to Optimize Community-Oriented Primary Care

In order to optimize community-focused primary healthcare in a time of chronic disease and obesity, the chronic disease prevention framework must be utilized, recognizing that the elements apply to infectious disease prevention and control etc. Core capacities of an integrated system include leadership, coordination, and collaboration; knowledge exchange and capacity building; surveillance, evaluation, and research; program development; policy development; communications; financial transfers and human resources. We must ask whether our current chronic disease prevention frameworks over-emphasize the provider, whether we have done enough on the community side, and whether we are focusing enough on the linkages between providers and communities. Thus, enablers of COPCs include community engagement, collaboration, leadership, information, resources, flexibility and technology. We need to leverage technology to support COPCs via surveillance of community health to better understand disease trends and risk factors at the practice and community levels. Data needs to be collected, integrated, analyzed and disseminated at the community level. It is also important to implement electronic health records. Overall, research must focus on the conceptual/theoretical basis for models, tools for more rapid implementation, performance measurement, economic evaluation, assessment of outcomes, evaluation of development and success of multidisciplinary teams, and evaluation of community engagement.

Plenary 5 – Primary Care Teams: Practical Approaches for Integrating Practitioners into the Team and Evaluating Team Functioning

Featuring: Louise Nasmith, Ivy Oandasan

According to the Romanow Report, good primary healthcare is based on interdisciplinary teamwork, with care available to all, 24 hours a day, 7 days a week. Collaborative patient-centered practice is based on the family/community and optimizes staff participation in clinical decision making within and across disciplines and fosters respect for all. Investment for primary healthcare reform has



been long-standing, including the Primary Health Care Transition Fund (\$800,000,000 investment in primary healthcare) and increased funding at all levels (Municipal/Provincial/Federal).

The Benefits and Key Ingredients of Interprofessional Primary Healthcare Teams

Interprofessional primary healthcare teams improve patient, provider and organizational outcomes. In terms of what is known about effective team functioning, teams are being formed and work is being done to provide team-based collaborative care. The key ingredients for effective team functioning are a shared vision, individual capacity to collaborate, interpersonal work process (conflict management), and communication methods/mechanisms, within and between team boundaries. Factors that affect team functioning include leadership, organizational structures, work practices, and rewards, resources, and tools.

Problems with Evaluative Measures

It remains unclear whether provider satisfaction in team models results in more retention and recruitment to primary healthcare. Evaluative measures have looked at summative outcomes and have not measured team functioning. In addition, it is not known exactly how team functioning impacts outcomes because the comparability of studies is difficult. A plan for rigorous and quality primary healthcare evaluation and research concerning primary care team functioning should be developed and implemented. In addition, validated Pan-Canadian evaluation tools measuring interactional, organizational, contextual and cultural indicators for team functioning are needed.

Direction for Policy and Research around Primary Healthcare

Following the presentation, the audience was asked to discuss amongst their group and identify one or two bold statements that should help give direction for policy and research around primary healthcare. Statements included the following: we are approaching this assuming that multidisciplinary teams are the way to go – we need to make sure of this first; there is no clear definition of a team – we need research to determine what a team is; students should be empowered to work in teams, with reverse mentorship so that they can encourage current professionals to do the same; and patients should act as “sniffer dogs” to determine if teams are functioning well.

Panel 3 – Practitioner-Researchers Comment on the Reality of Collaborative Teamwork

Featuring: Rachel Bard, Paula Brauer, Alba DiCenso, Lisa Dolovich, John Service

Collaborative Teamwork Generally

The panelists raised broad themes with respect to inter-professional primary healthcare and research. All four presenters spoke positively about the need and potential for inter-professional teamwork and collaboration and the recognition that there have been successes in different areas. They highlighted that they were only a sample of the many professions that could have been on the panel. They also spoke about the challenges and barriers to collaboration, the importance of identifying roles and scopes of practice, the development of trust and openness, and education. They also touched on political challenges and tensions among professional groups. The panelists also spoke about the role government plays in this process. Some were critical that the government has not involved all professions in dialogue about change. In addition, they spoke about the fact that inter-professional care will continue to evolve as new professions are included in primary healthcare teams and established professions are given new roles.

Audience Comments

The audience reflected similar themes to the panelists, adding their own perspectives. With respect to collaboration, a family physician further elaborated on the difficulties of finding the right mix of services. Panelist Lisa Dolovich answered that there are many possible models and that it is important to determine roles at the outset. A naturopath and a chiropractor each suggested that giving patients the choice can be a good approach. A family physician stated that it is not just



about the right mix and specified roles, there is also the need to recognize variability in competence. A pharmacist stated that a structure with potential for collaboration already exists with community-based pharmacists but currently pharmacists and physicians do not have relationships.

The Government Role in Collaboration

With respect to the government role in collaboration, a physiotherapist asked what they should do to get formally incorporated into primary healthcare. Panelist Paula Brauer responded, describing the process that nutritionists in southwestern Ontario followed. They formed their own group, sorted out what they saw as their own role, and then advocated for their position. She advised that professions take every opportunity offered to advocate for their case. A chiropractor suggested that alternative and complementary practitioners should be included in discussions about primary healthcare teams.

Accountability and Liability in Team Settings

Another topic raised was that of accountability and liability. In a team setting, who is responsible, especially if something goes wrong? Panelist John Server replied that case law suggests that the accountability will be with the person with the scope of practice most relevant to the particular issue at hand. He reiterated that despite this, teamwork continues to be about trust.

Electronic Health Records

Plenary 6 – Using Health Information Effectively to Improve System and Patient Outcomes

Featuring: Dr. Andrew Wiesenthal

KP HealthConnect

Dr. Andrew Wiesenthal spoke about Kaiser Permanente and the lessons learned and benefits realized from its health IT. Kaiser Permanente is the United States' largest nonprofit health plan, whose mission is to provide affordable, quality healthcare service and to improve the health of its members and the communities it serves. KP HealthConnect was described as more than just an electronic medical record, being a highly sophisticated information management and delivery system. It is a program wide system that integrates the clinical record with appointments, registration and billing. The system allows instant access to medical records for physicians and patients.

The Benefits of KP HealthConnect

KP HealthConnect is transforming quality of care. For example, longitudinal electronic health record and population support tools expand preventive and proactive care to chronic care members on a never before seen scale. The system is enhanced with clinical content, including access to a library of KP knowledge and best medical practices at the point of care, tools and templates that facilitate the delivery of evidence-based medicine, decision-support tools that enhance quality and patient safety, drug interaction and allergy alerts etc. Patient empowerment and convenience has also been increased. With secure e-mail messaging, patients can communicate with their doctors, view their record, and manage their care at any time. Patient safety has also been improved, with reductions in hospital medication errors. Physician and nurse resistance was not an issue, and patients love the system, have high expectations of it, and are not excessively worried about privacy.

In addition, while KP HealthConnect was designed specifically to improve care and service quality for its members, it has also resulted in operational efficiencies and cost-savings. Electronic records have saved millions in printing and storage costs. Long-term value is also expected. As much as one third of the \$1.8 trillion America spends on medical care is wasted on redundant procedures



and tests, disorganization and lack of timely information. Electronic health records help correct these issues by simply making all necessary information available at each point of care.

Barriers and Unintended Consequences of Information Technology

There have however been barriers to utilizing information technology to improve patient care, including the culture of healthcare, process, technology, the healthcare system and the environment. There have also been some unintended consequences, including errors in the process of entering and retrieving information, and errors in the communication and coordination process.

Suggestions for the Way Forward for Primary Healthcare

Plenary 7 – Conference Summary – Making Change Happen in Primary Healthcare

Featuring: Dan Florizone, Dr. Joshua Tepper

Moderator: Brian Hutchison

Brian Hutchison

Primary Healthcare Essentials

Hutchison discussed some primary healthcare essentials, including a policy roadmap anchored in public values, needs and preferences; primary healthcare governance mechanisms at the provincial/territorial and regional/local levels; patient enrolment; interdisciplinary team-based care; funding and provider payment arrangements aligned with health system goals; health information technology that effectively supports patients and providers; quality improvement linked with ongoing performance measurement; and systematic evaluation of innovation.

Dr. Joshua Tepper

Dr. Tepper reflected on the Summit and developments in Ontario and provided his perspectives as an Assistant Deputy Minister and as a general practitioner within the community.

What is Primary Healthcare?

Primary healthcare is defined as the first point of contact between a patient and the healthcare system. It is the navigator of the healthcare system, providing clinical services close to home and providing system access and continuity of care. It includes illness prevention, health promotion, diagnosis, treatment, rehabilitation and counseling. The goals of primary healthcare should be to provide interdisciplinary team-based around the clock care, improved system navigation and access coordinated through primary healthcare, and a focus on prevention, health promotion and chronic disease management guided by local population health indicators. Primary healthcare should also provide active support for the patient's self-care responsibilities.

The Difficulties in Finding Solutions in Primary Healthcare

Dr. Tepper recognized that there is no cookie cutter solution in primary healthcare. The types of primary healthcare models are fundamentally different, with a huge blend of different approaches. Recognizing the heterogeneity is a key to understanding policy and the need to take a multi-focal approach to primary healthcare. Dr. Tepper stated that we need to ask if we know where we are going. We should then ask if we are moving in that direction and if we are there yet.

Suggestions for a Way Forward

There is an opportunity to capture change – educators, frontline care givers and researchers need to push towards a common end state. We also need to determine the overall vision by identifying elements of successes, review priorities, evidences and gaps, and identify actions that should be started in the short, medium, and long terms. In addition, we need to identify the strategic



partners and who should be at the planning table. We also have to understand government time frames. In government, a week is a long time horizon. By the time you get the players ready to go, they may have changed.

Dr. Tepper commented that the primary healthcare agenda should be for all. It should be cheap, reproducible, and easily replicated. Belief in leadership is also critical to success. The implementation of Family Health Teams (FHTs) is the central transformation strategy through which the government is providing more Ontarians with access to primary healthcare and reducing the number of Ontarians without a family physician. Dr. Tepper identified a series of initiatives underway or undertaken to address primary healthcare alignment, including providing clinical services close to home, providing system access and continuity of care, illness prevention, health promotion, and improvement in diagnosis, treatment, rehabilitation and counseling.

Dan Florizone

The Need for a “Patient-First” System

Florizone commented that a patient-first movement is required which must be embedded as a core value in our healthcare system. Patients want a sense of community, care when they need it, personal care, a non-judgmental environment, and empowerment. The challenge is to consider the contribution healthcare professionals can make to achieve a health system that is truly patient-first. We currently operate in a system that is not well connected, but we need to hear patients’ stories. Florizone highlighted Sweden’s system, which has gained national and international recognition for making and sustaining large-scale improvements in healthcare. “Esther” is a persona that clinicians in Sweden invented to help them improve patient flow and coordination. This was used as a starting point for identifying and working on improvements in the way patients flow through the care system. Much work was done to align capacity with demand and to strength coordination and communication among providers to achieve a holistic approach.

Part of primary healthcare is the need to be connected; having a sense of community with support that fosters individual empowerment. However, family physicians have been left to operate to the best of their ability with no sense of community. Patients ask that healthcare workers and their respective leadership see beyond their declared interests so that the interests of patients can take precedence at every care interaction and every policy debate. We need to examine all processes through a value lens as defined by the patient, and the best interests of patients must be the primary driver of policy decisions, priority setting and resource allocation decisions. Service and care delivery should be considered first; with research being a means to an end, not an end in itself.

Suggestions for a Way Forward

Florizone emphasized the need to look at a policy roadmap anchored in public values, needs and preferences. Primary healthcare needs a governance mechanism – patient involvement and interdisciplinary team based care. The challenge is how to spread this across jurisdictions. There is a need to focus on innovation and innovation spread as well as a need to engage health system partners and build capacity for transformative change and improvement.



Concurrent Workshops

Day 1: Monday January 18, 2010

1.1 Canadian Cardiovascular Harmonized Guideline Endeavour (C-CHANGE): An Innovative Knowledge Transfer Platform

Hosted by: ICRH and PHAC

Featuring: Denis Droiu, Janusz Kaczorowski, Peter Lin, Peter Liu, James A. Stone

The Purpose and Benefits of C-CHANGE

The purpose of C-CHANGE is to harmonize cardiovascular prevention guidelines. This harmonization should be helpful to primary healthcare where there is limited time, many areas to cover with patients, and where patients have multiple conditions and risk factors to consider. The guidelines will be informed by evidence, implementable, and will lead to improvement in patient outcomes. The goal of the workshop was to take advantage of the expertise and insight of the participants, to bring organizations together, and to learn how best to manage the guidelines.

Barriers and Keys to Guideline Integration

The developers characterized C-CHANGE as a “metaguideline process” that will integrate guidelines for multiple risk factors at the patient level. The challenges of multiple risk management and multiple disease management were discussed, including the plethora of guidelines that are available. While it may be confusing that guidelines sometimes conflict, this means that the guidelines are evolving and improving as the evidence grows. There are internal barriers (e.g. information overload, guidelines based on poor evidence) and external barriers (remuneration methods, organizational inertia). The keys to successful guideline implementation are to keep it simple, have an integrated and unified message, and create actionable steps.

The Role of Harmonization of Guidelines

There was discussion concerning the guidelines themselves and the role of harmonization. One participant suggested that there is a need to prioritize guidelines. Workshop presenters agreed, stating that the intention is to have guidelines categorized by impact from highest to lowest, with recommendations to focus on the must do guidelines. Another participant suggested that it would be helpful to know how to apply guidelines in different populations to obtain maximum benefit. It was thought that harmonization is still a reasonable goal since there are still some areas of disagreement with particular guidelines. Also, guidelines will change over time and a group devoted to harmonization could stay on top of these changes.

Concerns of Consistency, Adaptability and Implementation of Guidelines

There was discussion about the consistency of guidelines with respect to who delivers them. There was also concern that guidelines be adaptable to different environments. The focus might vary with different providers or if the patient has different goals. The implementation of guidelines was also discussed, especially with respect to efficacy versus effectiveness. If in primary healthcare, effectiveness was embraced rather than just efficacy, this could dramatically change the implementation of guidelines. Guidelines would need to look at all chronic diseases to handle people with multiple conditions. The idea of a common metric could be developed to compare the risks and benefits across different diseases. One concern however with simplification of the guidelines is that simplification may move away from evidence.

The Communication of Guidelines

Another theme raised was how to get guideline information to providers and to patients. The role of the media was examined, with the concern that conflicting guidelines are what the media focuses on. It was suggested that information exchange should be as simple as possible and might require



different strategies for different audiences. For physicians, it could be incorporated into EMRs. For patients, it could be checklists in magazines. For journalists, it could be special workshops. It was suggested that the democratization of guidelines would be helpful, moving them to patients, and supporting patients in self-management.

1.2 Primary Care System and Practice Change: Complex or (Merely) Complicated?

Repeated on Day 2

Featuring: Brenda Zimmerman

Complex Systems in Primary Healthcare

Brenda Zimmerman discussed the attributes of a complex system, and distinguished a complex system from a complicated system in the context of primary healthcare. A number of interdependent attributes of complexity were discussed, and a complex system was summarized to include: relationships and interdependence; a system that is always in transition; one with simple rules; embedded systems (systems within systems); an understanding of non-linear impacts (e.g. why inputs don't always = outputs); and outcomes that are not predictable in detail. There was some discussion about the importance of asking good questions as a way to provoke an understanding of complexity. Simply just posing these so called 'wicked questions' often can frame an issue in a new way and help our understanding. In this way, the asking of the question may be more important than the answer.

Framework for Leaders in Primary Healthcare

Zimmerman offered a framework based on some upcoming research as a way to think about what kind of leaders we need in primary healthcare. The basic idea is that the role of the leader or system participant changes depending on both the level of technical and social complexity. Four types of leadership approaches for handling policy-making were set out:

1. Director: situation has low technical complexity, low social complexity; policies can be prescriptive and often very detailed;
2. Cartographer: high technical complexity, low social complexity; top down template created with several options; in short, the leader creates a map to guide the process;
3. Partner: high social complexity, low technical complexity; involved in coordinated engagement with key players outside the government; policies are co-created frameworks; and
4. Guide: high social complexity, high technical complexity; set key principles that must be upheld, allows flexibility on a local level for policies to be implemented that match the context.

Main Components of Sustainable Change

Zimmerman then explained another framework which includes the three main components of sustainable change, being values/beliefs, routines/behaviours, and resource flow. There is no order in which these three components must occur, but they are all necessary for change, all influence one another, and can be utilized in many different levels of the health system.

The workshop then broke out into small groups to discuss this question: From your perspective as a healthcare provider, administrator, or policy maker, what would those three components look like if we saw primary care as complicated? What if we viewed it as complex? The groups were organized under the following titles: Administration, Delivery, Policy, and Research. The Administration group stated that incentives can support good/bad behaviours and often lead to a more complicated system. In addition, challenges of innovations in primary healthcare are not



being given enough time to show results, with the resource component being shut off too quickly. The Delivery group commented that physicians do not always understand complexity, so they revert to making things complicated. However, there should be recognition that complex does not always mean more costly, and that the solutions to complex problems are often simple. The Research group stated that research that incorporates complexity is messy, difficult to get funded and difficult to publish. Finally, the Policy group noted that current evaluation models are driven by simple, complicated situations. Some innovations are pending that develop evaluation tools that account for complexity. The session ended with the overwhelming sense that an acknowledgement of the complexity of primary care at all levels would be beneficial to policy-making and the entire 'change' process.

1.3 Involving Primary Care Practitioners in Efforts to Improve Practice Quality and Outcomes

Featuring: Dr. Nick Kates and Dr. Rob Wedel

The objectives of this presentation were to explore what quality care is, define what needs to be changed, explore why systems underperform, introduce practical tools that can be applied at the practice level to help implement quality initiatives, clarify what is needed to implement system and practice redesign, and contribute to the Canadian research agenda on what more we need to know.

Problems with and Solutions for Canada's Primary Healthcare System

The Canadian system is lagging behind because other countries have moved forward much faster than we have, with the biggest concern being access to care. Although Canada's healthcare has many pockets of best practices, we have been unable to go from common care to best practices nationally. The traditional organization of care has been focused on acute care, with short, unprepared appointments where follow-up is usually initiated by the consumer. In addition, there have been difficulties with measurement, lack of leadership, lack of communication, and a misunderstanding of needs between professionals. A reorganization of systems is needed. Good clinicians in poor systems have average results. Poor clinicians with great systems have better results. We need a paradigm shift towards a focus on populations, longitudinal care, co-ordination, taking responsibility, teamwork, and information technology.

Components of Quality Care

The components of quality care include: access, effectiveness, comprehensiveness, patient-centred care, patient satisfaction, continuity across providers, equity, safety, efficiency and effectiveness, transparency, timeliness, and collaboration. It was questioned whether as we improve quality of care, we can achieve three different outcomes at the same time (i.e. improve the health of populations, the experience of care, and reduce the per capita cost). To improve quality, we need a framework for looking at the systems of care to identify where there is room for improvement (such as the Expanded Care Model). Through this framework we can identify change concepts and introduce improvements. Learning collaboratives have been recently introduced where groups get together to learn from each other over time. This stimulates a culture that supports innovation and improvement that is substantial, not just cosmetic.

Areas for Improvement in Primary Healthcare

Access is an important area for improvement since delays cost money and create redundancy. 'Knowing your patients' shifts doctors away from seeing patients individually right after the other to better managing patients. Clinics can work toward reducing demand for appointments through continuity, increasing return intervals, using telephone and email, and carefully developing the team to share responsibilities with other players. Clinics can also increase capacity by optimizing rooms, predicting needs, pre-visit planning and preparing, optimizing the care team, and sharing medical appointments.



To best engage clinical staff in quality and safety we need to discover a common purpose with reframed values and beliefs. Within the team, champions and laggards need to be identified, and improvement methods need to be used. A discussion followed on other ways clinical staff can be engaged in quality and safety. Ideas included changing how clinicians are paid by introducing a pay for performance system to change behaviors and attitudes, encouraging communication and engaging all staff, and looking for quick successes and visible wins to build motivation. Two directions for research in the area were also discussed, being using data to convince policy makers to think differently, and increasing funding to evaluate practices.

1.4 Implementation of an Interprofessional Approach to Shared Decision Making in Primary Care

Repeated on Day 2

Featuring: France Légaré, Dawn Stacey

This workshop focused on the implementability of an interprofessional approach to shared decision-making and identifying a research agenda for this area. Studies show that patients benefit from participating in shared decision-making. Moreover, interprofessional shared decision-making is important for expanding primary healthcare services to include other health professions and overcoming barriers to implementing shared decision making in primary healthcare. Shared decision-making involves a final decision point, presentation of evidence, recognition for uncertainty, incorporation of patient values, discussion of implementability, following regulations, clarifying agreement, making a choice and arranging follow-up. A quality decision is informed with the best available evidence and based on patient values. There is however a grey zone of decision-making. For example, of 2500 common treatments, evidence shows that 83% are probably beneficial or harmful.

The presenters set out their analysis of the various steps explicitly or implicitly undertaken to make a decision and highlighted the central role that evidence and patient values should play. The need for new models of shared decision-making was established based on the premise that healthcare services are increasingly delivered by teams of health professionals. Informed by a systematic review of the barriers and facilitators of shared decision-making, a workshop and interviews with 79 key stakeholders, such a model was developed to inform further progress in this area. The new model sets out the stages of shared decision-making: identifying the decision to be made, information exchange, considering values/preferences, assessing feasibility, preferred choice, actual choice, implementation, and outcomes. Family and various health professionals are involved throughout. Barriers to this new model include: time constraints, resources, imbalance of power, organizational structures, and practicing in silos.

1.5 Measuring Patient-Centred Care

Repeated on Day 2

Featuring: Moira Stewart

Components of Patient-Centred Care

Moira Stewart stated that Listening for Directions III and the Ministry of Health and Long-Term Care each identify patient-centred care as a priority and give their own definitions. There are six interacting components of patient-centred care, being: explore both the disease and the patient's illness experience, understand the whole person, find common ground, incorporate prevention and health promotion, enhance the patient provider relationship, and be realistic.

The Importance of Patient-Centred Care

Patient-centred care is important, in that 75% of patients expect it and it makes a difference to patient satisfaction, patient health and the efficiency of health care. Patient-centred visits tend to be longer when covering prevention/promotion but not when they are just exploring the disease



that the patient presented with. Patient-centred care does not have to involve a long list of questions; it takes into account that everyone wants/needs something, but you have no idea until you ask. It can be a simple open ended question such as “what’s the main problem/what do you want to deal with today?”

Strengths and Limitations of Patient-Centred Care Measures

There are made-in-Canada measures of patient-centred care, which occur after a patient visit, through population level surveys (Canadian Survey of Experiences with Primary Health Care), and at the program/organization level. Small groups at the workshop discussed the strengths, limitations and gaps in these three tools, with the general impression being that scales were useful depending on what you were trying to measure. With respect to measures after a patient visit, one concern was that such measures would miss the inner city street population, who are a challenge for follow up. The limitations of population level surveys were also discussed, including the concern that patient perception may not reflect what really happened, closed surveys may miss information, and that such surveys present a problem for children (wording does not target them) and the elderly (frailty, cognitive level, surrogate interviewees etc.). Also, with respect to all three measures, access and team based care were not taken into consideration.

1.6 Addressing Inequities in Primary Healthcare: One Size Does Not Fit All – Why Gender Matters in Patient-Centred Primary Care

Hosted by: IGH

Featuring: Dr. Joy Johnson, Dr. Blye Frank, Dr. Susan Phillips

Introductory Comments – Dr. Joy Johnson

It is important to understand that gender is not a unitary or fixed notion and that it can be expressed in many ways (via roles/relations/identities/institutionalized gender). It is the Institute of Gender and Health’s role (CIHR) to emphasize both sex and gender as important and distinct factors in men’s and women’s health. For instance, prescriptions have been tested primarily on men, although women are more frequent users of the healthcare system. Thus, patient-centred care requires a gender perspective (recognizing that gender is intersected by race, class, ability, etc.) to enhance the effectiveness of clinical interventions.

Gender and Primary Care – Dr. Susan Phillips

The effects of social factors such as gender on one’s health often disappear when health practice is reduced to a focus on disease or particular body parts. Health markers such as longevity must be seen as affected by social factors (i.e. masculinity is associated with risk taking behavior, thus men often die earlier than women). Within research, there is a need to find better methods to identify both: a) the effects of gender (beyond stratifying for sex) on health; and b) the ways gender interacts with other social factors (i.e. social economic status, marital status, etc.) to effect health. This requires moving beyond the dogma that randomized controlled trials are the most robust type of research or we risk ‘randomizing away’ important contextual variables affecting health. Studies have shown clinical trials to have poor generalizability on the general population, and the inclusion of sex-specific data often remains invisible today. We must move beyond absent or homogenizing evidence regarding men and women to tools and methods that consider the complexities of sex and gender. Some promising directions include studies that have looked at the relationship between gender relations, health care, and health. At the provider level, the more time and energy put into understanding patient contexts and experiences, the better the patient outcome will be.



Health, Illness, Men and Masculinities (HIMM): Issues for Primary Health Care – Dr. Blye Frank

There is a need to make the connections between patient-centred care and social location. Gender, and in particular, masculinity, must be considered as a socio-determinant of health that is enacted and practiced rather than embodied. For instance, the gendered socialization of boys and men and the perpetuation of hegemonic masculinity contribute to the health risks they experience (i.e. risk taking, denying illness and avoiding care etc.). There is also a need to recognize how gender is intersected by other social determinants such as race, class, and sexuality. Research methodologies must take into account more people's voices in order to understand the social construction and often political nature of research 'data'. Further, masculinity must be considered as changing according to time and place thus can be thought of as masculinities. The HIMM (Health, Illness, Men, and Masculinities) initiative promotes men's health through this conceptual framework to increase gender-sensitive education and policy to improve men's health outcomes.

1.7 Supporting Patient Self-Management: The WISE (Whole System Informing Self-Management Engagement) Approach

Featuring: Anne Kennedy

The WISE approach involves each of the patient, professional, and the NHS system. The aim for patients is for them to make better use of self care support through information support. The aim for professionals is for them to provide better self care support through changed behaviors/response (assessment, shared decision making, patient partnership, support change). The aim of the NHS is to improve access to self care support through improved training and patients' access to data. WISE is evidence based; it engages and supports patients, improves clinical responsiveness and changes access within health systems. In order for self care support to succeed, it must work for patients, professionals and fit within the NHS organization; include different ways patients self manage; build on existing skills of patients and professionals; and ensure that those from harder to reach backgrounds are included.

In evaluating WISE, it was found that self care support was workable and acceptable to patients and clinicians, and that a whole systems approach was key to WISE's sustainability. However, clinicians found it hard to provide self care support in every-day practice. GPs saw it as the nurses' role, but self care support was not the nurses' main concern during review consultations. Although self-management was viewed as important, it was not seen as a priority. Practice support staff also struggled to keep aware of locally available self care support options. After the evaluation was conducted, a Self-Care Directory was created listing references and local support groups.

1.8 Using System Data to Assess and Improve System Performance

Featuring: Patricia Sullivan-Taylor, Richard H. Glazier, Alan Katz, Greg Webster

CIHI's Primary Health Care Information Program of Work

Greg Webster discussed CIHI's Primary Health Care Information Program of Work. He emphasized that stakeholders need better primary healthcare information to help jurisdictions establish effective policies and programs by monitoring and understanding primary healthcare. CIHI can respond to stakeholders' primary healthcare needs with two types of solutions, being data (enhance the scope and quality of data through standards and data development) and information (produce indicators and analyses that are relevant, actionable and address the need to monitor, understand and improve primary healthcare). At present, some data gaps have been addressed but much remains to be done.



The Manitoba Centre for Health Policy

Alan Katz described the Manitoba Centre for Health Policy (MCHP), whose mission is to provide accurate and timely information to healthcare decision-makers, analysts and providers, so they in turn can offer services which are effective and efficient in improving the health of Manitobans. He also described the structure of MCHP's population-based health registry which combines more than ninety databases to enable the linking of data from a variety of sources.

The Use of System Data

Rick Glazier spoke of using system data to assess and improve system performance. He elaborated on a collection of databases which can be linked for the purposes described above, and described that despite the availability of data resources, gaps remain.

Data as a Means to Encourage Provincial Cooperation

A workshop participant inquired about making decisions in the absence of data. The panelists responded that provinces cannot be forced to work together, however if Ministry workers are shown the value of working with other jurisdictions, they may take it upon themselves to initiate cooperative efforts. Data may be used to make administrative reports as a means by which to quantitatively demonstrate the value of working together. Also, we must look at what is currently being done within Canada to learn about what is working and consider local implementation of other teams' successes.

Breakout Session Discussion

The workshop's breakout session examined two topics:

1. Quality initiatives on chronic disease prevention and management

Key messages included the fact that existing data is mostly at the practice level, and that we need patient experience-data, process data, and non-health data. Also, in the implementation of EMRs and EHRs, collaboration is imperative to ensure a coordinated mechanism.

2. Collaborative care initiatives

Key messages included that we must recall that we are in the very early stages and must build capacity. Additionally, we need non-physician data, a national coordinating body, EMRs that can provide standardized data, and linkages across data sets. Finally, we must measure and determine effectiveness as we move forward.

1.9 Performance Measurement and Evaluation of Primary Care Delivery Models: Evidence and Measurement

Featuring: Marie-Dominique Beaulieu, Jeannie Haggerty, William Hogg

Problems with Performance Measurement in Primary Healthcare

Innovations in and reforms to primary healthcare systems are occurring across Canada and worldwide. Care providers and policy and decision-makers need high-quality information to aid in decision-making and resource allocation. However, performance measurement in primary healthcare is not done as often as it should be. This is problematic, since publication of performance measurement results mobilize efforts for improvement. Measuring and reporting performance in primary care will quantify how providers are doing and how they can do better, which translates into better outcomes for patients. The patient should be maintained as the focus for measuring performance in primary healthcare. However, there is frequently tension between guideline adherence and patient preferences, and thus conforming to a guideline may not be in the best interests of the patient or provider. Providers may collect patient-centered data about a patient's experience in a chart; however, these data are not reviewed and used in the same way that guideline relevant data are used. As such, capturing the patient voice continues to be a problem.



Frameworks for Assessing Performance in Primary Healthcare

Several conceptual frameworks assessing performance in primary healthcare have been developed and used. Dr. Hogg presented his own framework, which was developed based on previous work done by Dr. Starfield, Dr. Watson and others. In his model, “structural” and “performance” domains are assessed. The structural domain seeks to examine the context within which care is delivered at the provincial/territorial and regional level. Examples of contextual elements that affect quality are health policies and provider remuneration mechanisms. The context in which performance is measured is critical; without it, providers may dismiss assessments as not applying to them in their own unique context. The performance domain assesses the direct delivery of healthcare services and the technical quality of care.

Challenges to Measuring Performance in Primary Healthcare

There are several challenges to measuring performance in primary healthcare. Indicators for any elements of care may have face validity with care providers, but must also be patient-centered. Additionally, as many dimensions as possible must be measured, else the performance picture will be incomplete. Incomplete measurement produces a bias towards information that is easy and inexpensive to collect.

The Use of Reflecting Teams

The discussion group engaged in a peer consultation process using four reflective teams. Each team was assigned a facilitator, and each group member briefly presented a challenge or problem they face in terms of measuring primary healthcare performance, with one issue of interest selected by the group for further discussion. The member whose issue was selected described the issue more fully, and the group was given an opportunity to ask questions and obtain more details. Next the presenter turned away from the group to maximize their ability to listen. The remaining participants formed a “reflecting team”, providing perspectives and solutions while the presenter listened. The presenter reported learnings back to the group at the conclusion of the process. Participants commented that the peer learning exercise was, in general, very useful. They noted that the small group work enabled them to consider an issue or question from a fresh perspective.

1.10 Developing an Indigenous Primary Care Agenda: Exploring Issues & Concerns in Health Service and Research

Hosted by: IAPH

Featuring: Dr. Malcolm King, Annette J. Browne, Lynden Crowshoe

Aboriginal Health Research: Addressing the Challenges to First Nations, Inuit, and Métis Wellness - Dr. Malcolm King

Challenges to and Determinants of Indigenous Health

Dr. King provided an overview of Aboriginal health research. He identified primary healthcare as an important Aboriginal health issue. There are many challenges to indigenous wellness, including infectious diseases, chronic diseases, mental diseases, injury and violence, barriers to access to healthcare, primary healthcare, and reconciliation and healing. Moreover, many non-genetic factors determine health, such as income, social support networks, education, employment, social status, working and living conditions, health practices, coping skills, childhood development, and available health services. The Aboriginal determinants of health include colonization, globalization, migration, poverty, access, cultural continuity, territory, and self-determination. Dr. King also noted that Aboriginal people have their own health solutions; living life in balance, spirituality, culture and identity, language, and song and dance are all important to their well-being.



Ways to Reduce the Health Inequities of Indigenous Peoples

One of the strategic directions for healthcare in Canada involves decreasing health inequities in Aboriginal people, which is now a CHIR strategic direction. The number one goal for the Institute of Aboriginal Peoples' Health is to facilitate and evaluate Aboriginal health knowledge, which also aligns with the CIHR strategic directions. In Dr. King's opinion, health public policy holds the greatest opportunity to improve the health and well-being of Aboriginal people living in Canada. We need to find common ground between the western worldview and the indigenous worldview in order to move forward. However, progress in reducing the health inequities faced by indigenous peoples will only be made if indigenous communities are engaged in the process of healing and revitalization by the mainstream, including researchers, health professionals and decision-makers. Interventions tied to social determinants should benefit not only the social development of indigenous people, but also their health.

Dr. Lynden Crowshoe

The BAHTLC Project

Dr. Crowshoe noted that the Aboriginal content in medical journals around the world is not proportionate to the Aboriginal population in those countries. He described the BAHTLC project, which took place from 2003-2007. The research question was: what are the significant cultural variables which influence the outcomes of clinical interactions between Aboriginal patients and physicians? For non-Aboriginal physicians, relationship building was central, and trust was important. Relationship building was also important for Aboriginal physicians, as well as respecting patients as individuals and taking a flexible approach. For Aboriginal patients, the central themes were respect, stereotyping and assumptions, relationships, and trust.

A Guiding Framework for Working with Aboriginal People

Dr. Crowshoe stated that the approach taken for Aboriginal health communication needs to first identify and address issues arising from Canadian/Aboriginal relations. Communication issues arise from power dynamics, assumptions, stereotypes, and oppression. Next, the influence of cultural norms on communication should be identified, and consideration should be given to utilizing these norms within the physician/patient interaction.

Dr. Crowshoe noted that there were no guiding frameworks for working with Aboriginal people, so he created one. Phase 1 involved looking at what service providers negotiate regarding culture and cultural competency within their roles. Here, researchers looked at how they dealt with Aboriginal peoples. Phase 2 involved developing research methods. The question focused on in this phase was: What do healthcare workers need to consider regarding local urban Aboriginal populations in respect to the health region's Universal Competency framework? Focus groups were then used, and in the end, a new competency diagram was designed, which added advocacy and relationship building to the competencies. The competency framework demonstrates how employees can effectively support the vision, mission, values and goals of the Calgary Health Region, with the universal competencies in the framework being communication, client-centered service, and teamwork. Core competencies include advocacy, relationship building, teamwork, patient-centred care, and communication. In conclusion, Dr. Crowshoe explained that when working with Aboriginal people, the focus should not just be on culture, but also on inequities.

Dr. Annette Browne

The Findings of a Partnership Based Study

Dr. Browne described her work on a four year partnership based study. Partners are urban health centers in British Columbia that are required to help any person in need. In one clinic, half of the patients self identified as Aboriginal. The goal of the study was to develop a preliminary set of indicators of primary healthcare that would account for the process of delivering care and the



impact of services on patient's health. This study showed that because of previous experiences, people are concerned with being judged within the healthcare system. The study also reinforced the significance of attending to socio-economic issues. One key dimension of primary healthcare services was found to be the creation of an open and accepting healthcare environment that deals with challenging behaviors in respectful ways.

Lack of Knowledge of Traditional Aboriginal Healthcare

By way of group discussion, the major gaps in knowledge related to primary healthcare and Aboriginal peoples were discussed. There is a lack of writing on traditional Aboriginal healthcare. One problem is that medical schools are missing any education on Aboriginal traditional healthcare. Currently, the dominant idea is that western ideas are better, and there is very little traditional culture within the medical setting. Naturopathic medicine and western medicines should be integrated, but it is difficult for traditional medical professionals to share naturopathic information with the medical profession because there is no universal acceptance of naturopathic medicine. Access should also be improved, and it should be recognized that when working with Aboriginals, you often need to invite them in order for them to advocate on their behalf or share their knowledge.

Recommendations for Primary Healthcare and Health Research in Aboriginal Communities

Recommendations regarding setting priorities for primary healthcare and Aboriginal health research were also discussed. The need to see what skill sets should be developed to help Aboriginal communities deal with healthcare was emphasized. There should be a focus on what the communities' priorities are. Moreover, there are a lot of people wanting to do research in Aboriginal health, but their knowledge of the communities is limited. As such, research ethic protocols should be developed for dealing with this type of research.

1.11 Diabetes Care: A Model for Other Chronic Diseases?

Hosted by: INMD

Featuring: Marcia Frank, Stewart Harris, Jeff Johnson

Moderator: Paul Bélanger

Healthy Eating & Active Living for Diabetes in Primary Care Networks (HEALD-PCN) - Jeff Johnson

Goals of the HEALD-PCN Study

Dr. Jeff Johnson provided an overview of an ongoing research study in the St. Albert /Sturgeon area, a Primary Care Network (PCN) environment, which is investigating new approaches to prevent and manage diabetes. The Plan is called the Healthy Eating and Active Living for Diabetes program (HEALD-PCN), a standardized lifestyle management program for type 2 diabetes. The goal of the study is to look at intervention methodologies, evaluation strategies for knowledge exchange, and sustainability in order to integrate these into ongoing practices. The program will evaluate behaviour, clinical component and ADSS linkages (linked with administrative data by looking at hospital and emergency care to fully evaluate the process) and cost effectiveness. The goals at the end of the study are to ensure the effective management of health promotion and clinical management of type 2 diabetes; advocate for an exercise specialist to be added to the diabetes primary healthcare team; link primary healthcare with local resources; and to establish an integrated framework with a knowledge translation to inform decisions on sustainability.

Primary Care Networks in Alberta

Dr. Johnson also provided some context around the Primary Care Networks, which are a made-in-Alberta approach that provide local flexibility for health regions and family physicians to meet patients' needs with a goal to increase access to and the quality of primary healthcare services. Currently over 1900 family physicians are operating in this PCN environment, and the goal is for



80% of Albertans to be cared for within a PCN by 2011. PCN is developed when a call is put out for a group of family physicians to come together to develop a business plan based on local needs and what they would like to provide in terms of primary healthcare services using whatever model they deem fit without any restriction. Family physicians are still paid on a fee for service basis in combination with a capitated funding for allied health services at \$50.00 per patient. Dr. Johnson stated that the PCN area of focus is to improve quality and access to care with a true emphasis on health promotion, disease/injury prevention, care of patients with medically complex problems and care of patients with chronic conditions. The intent is to improve the coordination of primary healthcare with other care services provided by the region like hospitals, long term care and specialty care services. The overall goal is to foster a team approach to the provision of healthcare.

The CIRCLE Study: Managing Diabetes in Aboriginal Communities - Lessons Learned from CIRCLE: Canadian First Nations Diabetes Clinical Management Epidemiologic Study - Dr. Stewart Harris

Issues with the Healthcare System and Health Problems on Reserves

Dr. Harris provided an overview of a recently completed study on managing diabetes in an Aboriginal Community and lessons learned from the CIRCLE research study. He highlighted the prevalence of type 2 diabetes in the First Nation population, which is 3-5 times higher than the general population. Complication rates and healthcare costs are also higher compared to the general population. He described the current healthcare delivery system in the First Nation population on reserves as being fragmented, with a number of barriers such as a high rate of staff turnover, limited or no surveillance, lack of infrastructure and resources, a high isolation level and a focus on acute rather than chronic care.

Description of the CIRCLE Study and its Findings

Dr. Harris stated that the first and fundamental step in addressing a population health problem is to accurately assess its burden and impact. The CIRCLE study was a three year national, coast-to-coast diabetes research study. Collaborative groups of First Nation communities in four provinces provided a snapshot for this study, including a mix of non-isolated, semi-isolated and isolated communities. The study created a diabetes registry of all the patients and monitored their charts, looking at factors such as the state of clinical management of type 2 diabetes in First Nation communities, rates of reported related complications and co-morbidities. Dr. Harris gave an overview of the Circle chart audit design and highlighted some of the outcome measures, being glycemic control and management, screening and management of concurrent conditions, as well as micro and macrovascular complications.

Dr. Harris highlighted some of the knowledge translation and dissemination activities which included wrap up meetings, community presentations, band council presentations, newsletters and media shows. Some of the CIRCLE key findings include: elevated levels of risk factors for heart disease; a high percentage of First Nation patients not achieving recommended clinical targets (i.e. poor blood sugar control and young age at diagnosis); and clinical care gaps including the lack of a smoking cessation program or a weight loss/control program.

Transition from Pediatric to Adult Diabetes Care - Marcia Frank

Weaknesses in the Transition from Pediatric to Adult Diabetes Care

Ms. Frank reviewed some of the effects and gaps in the care and transition of patients from pediatric diabetes care to adult care. Frank emphasized that it is vital to expend every effort to increase awareness of the organization of transitional care for young people with diabetes and prevent the loss of follow-up. During this period adolescents are at risk of dropping out of medical follow-up, an action which may interfere with their future physical and psychological well-being. When they graduate from pediatric care, some of these young people opt out of care altogether, only to resurface in the medical system when they develop complications which may have been



prevented. At the time of transition to adult diabetes care, dropout rates are reported to be in the range of 10-60%. There is currently no structured transition process available for youths transitioning from the pediatric system to the adult system, and actual transition practices in many places are far from optimal.

Suggestions for and Outcomes of Successful Transitional Care

Quoting the definition of the Society of Adolescent Medicine, Frank highlighted that transition should be a purposeful, planned movement of adolescents and young adults with chronic, physical and medical conditions from a child-centered to an adult orientated healthcare system. Transitional care should start early and strategies should promote uninterrupted, comprehensive, and accessible adult care. Moreover, there is a need to identify those at risk for poor transition and focus on this group. The principles of effective transition include starting early, reframing leaving the pediatric environment as an achievement, giving patients the opportunity to see healthcare professionals by themselves, involving the child/teen and their family in the transition planning, and using a planned, coordinated approach. Outcomes include reduced diabetes-related hospital admissions and a reduced dropout rate.

Day 2: Tuesday January 19, 2010

2.1 Practical Approaches for Reconciling Guidelines with Patient-Oriented Care

Featuring: G. Michael Allan, Ross Upshur

The Strengths and Limitations of Guidelines

The objective of this presentation was to discuss the strengths and limitations of guidelines and conduct a group exercise looking at how to apply guidelines and what they might offer. Guidelines are helpful in that they summarize the best information available and give suggestions where there is no evidence, saving time for practitioners. They are limited however in that the interpretation of guidelines can be skewed, there are complexities in applying evidence to real life contexts, providers may not be trained in applying guidelines in the context of patient complexities, finding out which guidelines are suitable and then navigating within guidelines for the answer to a question within a limited time frame is difficult, guidelines do not speak to how to convey information about risks to patients in understandable ways, recommendations are not always based on best evidence, but often 'expert opinion', a proliferation of guidelines depends on hierarchies in rating groups – what counts as grade A for one study may differ throughout different guidelines, and disagreement exists between task forces regarding guidelines. In addition, one study found that guidelines rarely included a discussion of patient-centered or shared informed decision making.

Allan and Upshur looked at the concurrent management of complex patients and found a huge variation in how patients manage medications, underlining the complexities of patient adherence with respect to their lives (i.e. splitting pills for cost savings, wariness of drug effectiveness, not keeping track of pills taken etc.). Guidelines need to help providers negotiate these patient complexities within their limited time frames. For instance, rather than focusing on hitting targets in guidelines, we need to focus on how well the patient is doing overall.

Participants' Use of Guidelines

Workshop participants were divided into groups and asked to discuss the following questions:

1. Do you use clinical practice guidelines? How?
2. Do you deviate from CPGs? What factors drive deviations? How do you justify deviations?
3. What would be an ideal solution, considering time and complexity?



Many participants used guidelines at the beginning of their practice, but less after learning about the process involved in constructing them. Many deviated from the guidelines, and it varied whether tension was experienced in doing this; others emphasized following a standard of care rather than guidelines *per se*; many used them if convinced it would make a difference but were wary that guidelines were not based on sound evidence. It was noted that guidelines presuppose a specific question or aim and mandate a specific action that may not be suitable given the patient context. It was also noted that guidelines are not based on trials that take into account patient lifecourse, social context or issues of polypharmacy or co-morbidity. New questions with patient-centred outcomes in mind are needed with respect to patient contexts, values, history, etc., ensuring the information is translatable to patients. This requires more research looking at application guidelines vs. prescribing guidelines. All stakeholders must work together and discuss standards of practice in transparent ways to improve healthcare services.

2.2 Primary Care System and Practice Change: Complex or (Merely) Complicated?

Repeated from Day 1

Featuring: Brenda Zimmerman

Distinguishing Simple, Complicated and Complex Decisions

This workshop focused on distinguishing between things that are simple (i.e. known), complicated (i.e. knowable) and complex (i.e. unknowable). Decisions are simple when there is great certainty and agreement on the options. Decisions are either socially complicated or technically complicated when there is less agreement and certainty respectively. Decisions that are both socially and technically complicated are within the zone of complexity. While single morbidity diseases are complicated, the multi-morbidity patients often seen in primary healthcare contexts are complex. Organizational issues also require complex approaches which differ greatly from those appropriate to complicated situations.

Modes of Policymaking

Different modes of policymaking are based on different situations. When there is both low social complexity and low technical complexity, the director mode can be used to dictate policy and how things will run. When there is low social complexity but high technical complexity, the cartographer approach can be used, where policies are maps or decision trees with the final branches delineating behaviours for each group. When there is high social complexity and low technical complexity, the partner approach is needed to co-design policy. Finally, with both high social complexity and high technical complexity, the guide approach should be used to create a set of key principles that must be upheld.

The Challenges of Complex Research

In the discussion, participants identified the problem that we often take simple things and make them complex, and take complex things and inappropriately try to simplify them. For researchers, it is easier to attract funding if they use the language of the complicated (i.e. what is knowable). Complex research requires interdisciplinary teams and does not necessarily know what is required in stage two until stage one is complete. As such, flexibility is essential.



2.3 Research Needs in Maternal and Child Primary Healthcare in Canada

Hosted by: IHDCYH

Featuring: Richard H. Glazier, David Bergman, Astrid Guttman, Virginia A. Moyer

U.S. Research Priorities for Pediatric Clinical Preventive Services from the Viewpoint of the USPSTF - Virginia Moyer

Moyer spoke about prevention strategies for children's health. There is strong evidence that some prevention strategies work and some do not, but for most recommended preventive services, there is a lack of strong evidence of effectiveness. There are research challenges in child and adolescent preventive services, including lack of sufficient data, less federal funding, and ethical/design issues limiting the use of randomized control trials. There are also questions as to what is sufficient evidence, what is a sufficient benefit and whether the trajectory potential benefit varies with age.

Child health should consider developmental trajectories (keeping children on the most advantageous path as they grow and develop), the influences of family and other caregivers on child and adolescent health decisions and outcomes, and building the chain of evidence to support clinical preventive services recommendations. Traditionally, mortality and morbidity have been the targeted outcomes of prevention, but increasingly outcomes concerning better quality of life are considered. When the USPSTF indicates that there is insufficient evidence to recommend an activity, this can spur the research agenda, and in turn lead to recommendations. Preventive services for children require a different analytic framework than adult services, since screening and prevention may be focused on the child or the parent.

The Who, What, When and Where: Re-designing Pediatric Primary Care for the 21st Century - David Bergman

Bergman spoke about the megatrends of pediatric primary care in the 21st Century. There will be a movement away from MD-based care to team-based care as well as an increase in non-MD professionals' and families' involvement in patient care. Care will be tailored both in content and delivery to individual patients. Patients and families will demand 24/7 care, and more types of care and information will be available through the internet. Pediatricians will increasingly look after children with special needs. Primary care will be unbundled, and not necessarily delivered in one place (schools, retail clinics etc.).

Trends in Primary Care Use for Canadian Children: Implications for Primary Care Reform - Astrid Guttman

Guttman spoke about the trends and challenges in primary healthcare service delivery for children in Canada, as well as the future direction for policy and research. Primary care for children includes well child care, acute care and chronic care management. Family physicians and general practitioners provide about 75% of care for children, with pediatricians providing the other 25%. The challenges and changes to care delivery for children provide some good opportunities for policy relevant research. It is particularly important to keep a close eye on the Health Human Resources dynamic, especially for the impact on the increasing number of medically complex children. Child health clinicians and researchers will not necessarily be involved in the discussions about primary healthcare reform, so it is important that we make the evidence known. There is a lack of researchers and a need to focus on aligning projects with policy interests. Major aspects of reform are changes in remuneration, increased access, funding for IT, performance measurement and greater use of allied health professionals.

The Incorporation of Pediatricians into Primary Healthcare Teams - Rick Glazier

New models of primary healthcare are increasingly found, but pediatrics has been left out of these reforms. Incorporating pediatricians into primary healthcare teams could provide shared care models between pediatricians and family physicians for child health and children with special needs.



Canada has done a bad job with things like child poverty, key determinants of health, and childhood obesity.

By way of participant discussion, the need for fostering child development as an outcome and viewing child health in a broader way was emphasized. It was recognized that when we speak of childhood outcomes for health, we are not always talking about medical outcomes but also education, criminal justice, and social services. In addition, we focus on access to care but for some disadvantaged groups access to care is not sufficient. Another issue discussed was that with both parents working, care is demanded after hours. There may be movement to more retail clinics and the idea of a virtual home rather than a physical space. The lack of research and policy focus on child care was also discussed. There was also concern that only randomized control trials have credibility, but that some childhood research does not lend itself to these. It was stated however that program evaluation and iterative methods of determining quality can be rigorous as well.

2.4 Implementation of an Interprofessional Approach to Shared Decision Making in Primary Care

Repeated from Day 1

Featuring: France Légaré, Dawn Stacey

The objectives of this workshop were to 1) explore the implementability of an interprofessional approach to shared decision-making based on the Inter-Professional Shared Decision-making (IP-SDM) model; 2) discuss facilitators and barriers to implementation; and 3) identify research priorities. Participants identified key barriers at the system, practice, and provider level that may impede implementation of SDM in primary healthcare.

Shared Decision-Making Programs

Patients face a variety of very difficult questions with regard to their own medical care, and with primary healthcare, may be making three to five decisions in a single consultation. Washington State now requires evidence that a shared decision-making process has occurred before a patient can undergo elective surgical procedures. Such evidence includes patient declarations that the patient and provider engaged in SDM and that patients had opportunities to ask questions, descriptions of the patient decision aid used, and patient satisfaction. There are plans to apply this approach across a variety of “preference-sensitive care and decisions”. There are also shared decision-making programs in place in Saskatchewan for joint replacements, prostate cancer, and the nurse help line.

Key Features of the IP-SDM Model

The IP-SDM model outlines a process by which patients are supported as active participants in their own decision-making, have their decision needs met, and reach healthcare choices that are agreed upon by the patient and their care team. Key features of the IP-SDM model are the focus on the process by which a decision is made, and the expansion of patient decision-making from doctor-patient to care team-patient. In IP-SDM, the IP team plays two roles: they initiate discussion that a decision needs to be made (“the initiator” role), and also coach the patient in making a decision (“the coach” role). The patient is centrally placed in the model. The decision process happens over time, and within an environment that is facilitative or not to this approach to decisions, and there includes the possibility of feedback loops, where the patient returns to previous steps.

Barriers to the Implementation of the IP-SDM Approach

The majority of the group discussion focused on the barriers of implementing this IP-SDM approach in primary healthcare. Barriers included the time consuming nature of the process, managing decisional conflict, the effect of culture and social norms on healthcare decisions, accountability for decisions, and problems related to the current health system structure and provider buy-in. The discussion group also posed several questions that should be addressed in order to further this



research area. Most questions focused on either decision aids or patient and provider outcomes.

2.5 Measuring Patient-Centred Care

Repeated from Day 1

Featuring: Moira Stewart

Refer to Day 1 – Workshop 1.5

2.6 Addressing Inequities in Primary Care: Can Innovative Models in Primary Care Delivery Address Socio-Economic and Cultural Inequities?

Featuring: Denise Brooks, Annette J. Browne, Adrianna Tetley, Sabrina Wong

The Benefits of Group Medical Visits

This workshop touched on and drew lessons from various primary healthcare delivery models. Sabrina Wong spoke of group medical visits which increase patients' engagement in their own care, and shift the inherent power differential between healthcare providers and patients. Also mentioned was a mixed model approach to examining access and response to the healthcare of children.

The Benefits of the Community Health Centre Model of Care

Adrianna Tetley elaborated on Community Health Centres (CHCs), which provide a model for dealing with inequities, and serve people who encounter a diverse range of barriers to access, individuals with or at risk of health problems, and communities at large. The CHC model of care is comprehensive, accessible, client and community-centred, interdisciplinary, integrated, community-governed, inclusive of the social determinants of health, and grounded in a community development approach. This Model of Care was presented as a proven, effective model for promoting health equity and addressing the impact of social, economic and political inequities.

Denise Brooks described the Hamilton Urban Core CHC and the successful programs and services it offers to its clients, sometimes in collaboration with other community organizations. One of its main focuses is on poverty as a health risk, a political choice, and an unacceptable human condition.

Study of Primary Healthcare Delivery in British Columbia

Annette Brown spoke of an ongoing study examining two sister clinics in Vancouver and Prince George, British Columbia, to understand how primary healthcare services are being delivered to Aboriginal and non-Aboriginal populations.

Examination of Innovations to Address Health and Social Inequities

The breakout session examined the top innovations in primary healthcare to address health and social inequities. Key issues included: the need to address social needs in addition to just health needs; being aware of the patient population and its specific needs; data regarding communities must be made readily available to practitioners; a primary healthcare team with a variety of knowledge bases from which to build; "Pathways to Education" – breaking the cycle to eventually increase access to healthcare; going to the populations who will not come to you; using models locally that are already in place and working in other jurisdictions within Canada; and recalling that we need not only advocacy, but also a business case – we need to think about what level of government and to whom exactly we should be presenting this information to get what we need.



2.7 Supporting Patient Self-Management: Successes and Challenges of Implementing the Stanford Model

Featuring: Judy Murray, Carla Palmer

Moderator: Christine Colcy

Chronic Disease Self-Management Program - Carla Palmer

Palmer provided an overview of the Chronic Disease Self Management Program (CDPM), which offers patients an appropriate suite of community and health services depending on need. Costs can be reduced using strategies like self management to push the service needs to a lower level. Similarly the effects of chronic conditions can be reduced by shifting resources to self management. The goal of the program is to reduce the effects of chronic conditions by shifting resources to self management.

The Stanford Model – Judy Murray

Murray provided an overview of the Stanford Model, a chronic disease self management program developed and licensed to Stanford University over the past twenty years. Programs are designed to help people gain self-confidence in their ability to control their symptoms and how their health problems affect their lives. Small-group workshops, generally six weeks in duration, meet once a week for about two hours. Workshops are led by a pair of lay leaders with health problems of their own. The meetings are highly interactive, focusing on building skills, sharing experiences and support. Active participation is required. Features of the Stanford Model include quality control, standardization, tailoring to the local community, and designs for peer learning. No physician referral is required.

Murray also provided an overview of the Ontario CDFM Framework. Currently the Ontario Patient Self Management Network operates on an informal basis with no mandate or funding. In reviewing some of the strengths and weaknesses she noted that there is strong public and political interest, and some provinces have regionalized the CDSMP program. However some of the weaknesses include a lack of national strategy, limited central leadership, inadequate resourcing and inconsistent delivery. Lack of personnel and resources, MD barriers and inequality of access are some of the threats to the program.

2.8 Using Electronic Medical Record (EMR) Data to Assess and Improve Practice Performance

Featuring: Patricia Sullivan-Taylor, Anne Holbrook, Alan Katz, Andy Wiesenthal

The Ontario Perspective – Anne Holbrook

Holbrook believes that we must curb our blind love affair with technology. EMRs require an enormous team of disciplines to make them work. Data quality requires constant vigilance, and systems are complex, with data extraction difficult. Consistent full data entry and smarter data extraction and query are needed. EMRs also need better population management tools. Holbrook stated that there is no high quality evidence that EMRs are effective in improving patient clinical outcomes or cost-effectiveness. High quality research methods should be applied, and a research consortium analogous to clinical trials networks is needed.

Alan Katz

Katz stated that other research methods (besides randomized control trials) may be valid for complex issues like this. At present, different clinics and clinicians use EMRs in very different ways, and many functions (i.e. what makes EMRs different than paper) are not always used. Getting the benefits from an EMR is more about the people than the system, and people must be properly trained. We should stop debating about whether EMR is a good thing or not and concentrate on helping people to use it effectively.



Lessons of Data Organization and EMR from Kaiser - Andy Wiesenthal

Wiesenthal spoke about Kaiser's experience with EMRs. Commercial systems were found to be very flexible. Certain very specific areas of the chart are structured (i.e. reason for visit, vital signs). The Care Plan is also highly structured, which is easy for physicians.

2.9 Performance Measurement and Evaluation of Primary Care Delivery Models: Physicians Dialogue on Primary Care Delivery Models

Featuring: Anne Doig, Dona Bowers, David M. Kaplan, Ernst Schuster

Environmental Scan of Primary Care in Alberta – Ernst Schuster

Schuster provided a perspective on what is happening in Alberta, which is typically a fee for service province, with some exceptions. Alberta has primary care networks, which are each different with different business plans, with 50-60% of GP's involved in these, as well as the Access Improve Measures (AIM) initiative. In 2009, funding enhancement in fee for service for chronic disease management was introduced; in exchange for developing comprehensive care plans for complex patients, physicians receive a fee of approximately \$200/year. In 2009, a Performance and Diligence Indicator Fund (PDI) was also introduced. PDI is the first step to finding out how many physicians there are with how many patients assigned to them etc.; the second phase of PDI is performance and quality indicators.

Schuster pointed out some of the limitations of a fee for service model. In this model, the physician is not paid unless there is direct patient contact. As such, there is low incentive to reduce the number of return visits, "maximum packing" visits are not rewarded, and email and phone communications are usually not paid. Responsibility for value for money is not well defined, and the physician gets paid if they see a patient with no questions asked about what they did. Funding should follow performance indicators, but currently there is very little accountability.

Schuster also touched on the road to quality comprehensive care. At present, more comprehensiveness means less income and higher overhead; any payment mechanism needs to reverse this trend and reward excellence. For quality comprehensive care, individual physician/team values should trump the payment mechanism. Any incentive to expand the team needs to be independent of physician earnings. Better infrastructure, access, continuity, team support and EMRs are all required.

Primary Care Payment and Delivery Models in Ontario – David Kaplan

Kaplan spoke about Family Health Organizations (FHOs), Family Health Networks (FHNs), and Family Health Teams (FHTs) in Ontario. FHOs and FHNs are healthcare payment models which pay on a blended capitation model for providing comprehensive care. There are after hours requirements, and physicians are rewarded with Q codes (incentive codes for providing services to targeted populations). Anything outside of the basket is reimbursed on a fee for service basis. FHTs are a delivery model that work in a non fee for service payment system. FHTs incorporate values of teamwork, cooperation and conflict resolution, and they help deliver on various government priorities including keeping people healthy and reducing wait times. FHTs have experienced both successes and challenges. For example, the North York FHT successfully created an H1N1 vaccination clinic and immunized faster than public clinics. However, with 18 vendors for EMRs in Ontario, electronic health records are a challenge. There has also been a change in the government commitment to the model, leading to micromanagement. In addition, not having a global budget is a big issue as it does not allow for flexibility. FHTs are also vulnerable as they have been unable to demonstrate successes. However, it is early days and they are on the road to progress.



Community Health Centres in Ontario – Dona Bowers

Bowers described Community Health Centres (CHCs), including their benefits and challenges. CHCs have been in existence since the 1970's; they are not the same province to province or within a province. CHCs have very targeted populations and serve those who encounter a diverse range of barriers to access, including the homeless and those without insurance. Many CHC clients are incredibly complex and CHC's are viewed as very expensive. CHCs are comprehensive, accessible, client and community centred, interdisciplinary, integrated, community governed, and grounded in a community development approach. Benefits include the use of interprofessional collaborative teams, with the most appropriate health professional addressing client issues; superior management of chronic diseases; emphasis on health promotion and primary prevention; and the fact that as staff are salaried, they are not time challenged and are not limited to face to face encounters. The fact that all staff are salaried however is also a challenge, as salaries have not been at the same level as some of the other models. Other challenges include the fact that EHRs are not working for CHCs and do not give them the information they want and the fact that clinical spaces are not the most efficient.

2.10 Primary Mental Health Care: Provincial Perspectives on Developing and Disseminating Practices to Enhance the Patient Experience

Hosted by: INMHA

Featuring: John Service, Dan Bilsker, André Delorme, Nick Kates

Supported Self Management for Depression: Translating Knowledge into Practice – Dan Bilsker

The Effects of Anti-Depressants

Although general practitioners often prescribe antidepressants for mild to moderate depression, evidence shows that this exposes patients to risk without benefit. The true effects of antidepressants are only seen in cases of extremely severe depression. In less severe cases, there is little effectiveness.

The Benefits and Challenges of Supported Self-Management

The project described in this presentation involved persuading general practitioners to provide patients showing signs of mild to moderate depression with a workbook based on cognitive behavioral therapy. Supported self-management (SSM) falls between treatment and knowledge transfer, where the healthcare provider is most often the coach. The SSM workbook is recommended as a first line treatment for mild depression and is thought to be a necessary part of standard care, providing doctors with options other than medication. Evidence shows a dramatically higher success rate for patients using the workbook with the guidance of a coach. The SSM workbook can be delivered in the regular ten to fifteen minute visit with a general practitioner. In addition, the program requires very little physician training, usually ranging from thirty to sixty minutes, and only costs about \$10 per intervention. The user-friendly workbooks were designed for various types of patients, and include Antidepressant Skills, Dealing with Depression (for adolescents), Antidepressant Skills at Work, etc. Social meetings were organized to convince doctors that the workbook was a fun and effective tool to use in their practice. Although it was effective in this case, implementation is still a problem among new treatments, and research should focus on marketing and implementation. The good news is that the project worked. SSM is an evidence-based, guideline consistent, physician embraced, inexpensive, easily trained intervention that enhances the patient experience. The bad news is that there is no mechanism in Canada to support national dissemination of this intervention.



Improving Collaboration with Primary Care: The Hamilton FHT Mental Health Program – Nick Kates

The Importance of a Strong Link Between Mental Health and Primary Healthcare

Kates discussed the importance of improving the links between mental health and primary healthcare. First, the family doctor is usually the main provider of mental health care, often without the support that he or she needs. Also, although mental health problems occur in a high percentage of the population, many mental health problems are undetected, especially for those with chronic diseases. Presently, there are problems in the relationship between mental health and primary healthcare, such that primary healthcare does not get the support it needs. One solution is to integrate mental health and addiction services into primary healthcare.

The Hamilton Family Health Team Mental Health and Nutrition Program

The Hamilton Family Health Team (FHT) Mental Health and Nutrition Program involves 80 practices, 149 family physicians, 350,000 patients, and 105 sites. The system is a stepped model. The general practitioner does as much as they can, then they involve the counselor for further resources. It is also a shared care model, with care shared between the physician and the health team. The health team integrates specialists, with a focus on personal contacts. The team focuses on short-term care, will see any patient of any age, provides indirect services, direct services, and telephone back-up. One of the major benefits is that the team facilitates navigation of the healthcare system for the patient. The family physician remains involved as the main provider of care, continue to prescribe all medication and still see the majority of mental health problems. The team provides support for the physician, allowing the physician to increase the range of cases they manage, and making them more likely to investigate a problem they may not understand.

Family physicians like the program and enjoy having psychiatrists and counselors in the practice. Patients are also satisfied. Since doctors often do not explore mental health issues that they do not understand, this program increases treatment as a result of the increase in resources available to doctors. It provides greater access to mental healthcare for patients, especially in underserved communities. Since the care takes place in the family clinic, it makes it easier for groups that are culturally resistant to seeking outside mental health care. The coordination of care improves communication between healthcare professionals and results in greater continuity and the integration of emotional and physical care. Services are easy to access, more culturally acceptable, occur in a familiar environment, provide help in negotiating the system, and are less stigmatizing.

Policy Implications of this Program

This project has many policy implications. It has shown that there is a need for collaboration at every level of the system, especially between planners at the provincial and regional level. Future practitioners should be trained to work in teams. Policy makers should focus on medical care for individuals with mental illness while improving care for those with general medical conditions. This project has also lead to more research questions and topics that revolve around improving population health, enhancing the consumer experience, and reducing costs while increasing efficiencies.

Primary Mental Health Care: Provincial Perspectives on Developing and Disseminating Practices to Enhance the Patient Experience - A Surrealist Task?: Developments in Québec - André Delorme

Problems with Mental Healthcare Organization in Québec

In Québec, healthcare was organized according to a postal code system that indicated where patients had to go for care. This posed the three challenges of: getting into the right door, as access depended on postal code and there were different referral mechanisms; getting in at the right time, as access to psychiatrists required general practitioner referral and waiting times were



lengthy; and getting to the right person, as access to any type of mental health professional had to be approved by a physician, usually a psychiatrist.

Objectives of the Mental Health Action Plan

Four objectives were set for the Mental Health Action Plan (MHAP), being recovery as the main focus of services; services build around a strong primary care environment; rapid access to mental health services; and a delivery model built on knowledge exchange and collaborative care. The MHAP was about opening more doors for patients. It involved the elimination of the postal code access system and forced all health centres to offer primary mental health services for adults and youth. Those centres with more than 50,000 patients were required to offer primary mental health teams on site and access wickets (one access portal to all services). Provincial guidelines were created with respect to the makeup of health centre teams, and now exist for waiting times. These health teams have had a positive impact on waiting times, and are now working toward computerized monitoring of access to primary and outpatient clinics. Mental health professionals were granted more autonomy, allowing psychologists and nurses to offer expertise and treatment plans without physician approval. The Health Ministry has also been producing guidelines to improve the quality of services across the province, including chronic care models, stepped care algorithms, self-care tools, promotion of Cognitive Behavioral Therapy and IPT. The major challenge of these changes has been for physicians to go from an independent 'lone ranger' mentality to a team work model.

In conclusion Delorme stated that reshaping mental health service delivery to enhance patient experience is possible. Provincial guidelines are useful in doing so. However, reshaping is not enough. Quality is central to any reshaping, and must involve networking and empowerment to work.

2.11 Research Gaps for Primary Care in Musculoskeletal Health – What are the Issues in Primary Care for the MSK patient and What Research Gaps Exist for Optimal Patient Care Management?

Hosted by: IMHA

Featuring: Gillian Hawker, Michael Hilmer, Linda Li, Carlo Marra

Moderator: Richard Birtwhistle

Research Opportunities for Primary Care in Musculoskeletal Health - Gillian Hawker

Musculoskeletal (MSK) conditions and arthritis are common and likely impact the management of other common conditions. Osteoarthritis is the most common form of arthritis, affecting 10% of the Canadian population. These rates will rise, at high costs to our healthcare system, due to increasing longevity, increasing obesity and decreasing physical activity. Primary care physicians play a key role in treatment, including maintaining longitudinal relationships with patients as well as acting as gatekeepers and coordinators for secondary care. However, there is inadequate surveillance in primary healthcare related to the study of arthritis, including inadequacies in population surveys, administrative databases and the minimal arthritis registries available.

Hawker listed the barriers she sees in regards to quality care for arthritis, including the lack of confidence in MSK evaluation, patients' and physicians' perceptions of arthritis as natural and a consequence of aging, co-morbidity, and the high financial cost of uninsured services. She emphasized the fact that implementation strategies to improve care require reliable measures to evaluate quality care. Hawker provided the group with three recommendations for primary care MSK research, being that we must validate diagnostic and procedure coding to enhance the use of administrative data, we should move away from "condition specific" research in chronic diseases, and we need a global chronic disease perspective to improve charting.



More than a Gatekeeper: Primary Care in the Management of Rheumatoid Arthritis - Linda Li

Li discussed the importance of primary care in the management of rheumatoid arthritis (RA). Primary care physicians play an important role in the continuum of RA care, and other health professionals appear to be willing and able to contribute to RA care also. Li recommended more investment in research in health services interventions that aim to improve appropriate help-seeking, referral and treatment and urged participants not to disregard the projects currently on the go (MoCA – CIHR Team in Model of Arthritis Care and the “Falling through the cracks” project). In discussion, there was concern that arthritis and MS are not on the agenda for primary healthcare. There was also concern that primary care physicians need to improve their referral practices, which could include medical education activities, shared-care and triage by nurses.

How Can Pharmacists Participate in Primary Care for Osteoarthritis (OA)? - Carlo Marra

Marra discussed the important primary healthcare role pharmacists play in the management of osteoarthritis. In relation to knee osteoarthritis, Marra emphasized two main care gaps, being gaps in the identification of knee osteoarthritis and gaps in the provision of care, including inadequate pain control, medication safety and comprehensive care.

While discussing the important roles pharmacists play in primary care, Marra introduced the group to a project, Pharmacist Identification of New, Diagnostically-confirmed, OA (PhIND-OA), the objectives of which were to determine if community pharmacists, using a simple screening questionnaire, could identify individuals with previously undiagnosed knee OA and to determine if intervention initiated by pharmacists could improve quality of care and outcomes. As a result of this project, it was found that the accuracy of diagnosis with a pharmacist and nurse was 98% versus strictly-defined ACR knee criteria which holds an accuracy of 82%.

In another project, Pharmacist-initiated Intervention Trial in OA (PhIT-OA), the objective was to determine if a pharmacist initiated, multidisciplinary intervention could improve quality of care and outcomes in knee OA. The outcome which followed referred to the difference in proportion of patients who received a “pass” on the Arthritis Foundation’s Quality indicators during the six month study. Marra concluded that community pharmacists could contribute to multidisciplinary care in OA and improve outcomes.

Michael Hilmer – System Management

Michael Hilmer informed the group of some problems with our present healthcare system and recommended some changes that are needed to improve the system. Presently, the governance of physicians in Ontario is non-existent and incentives for primary care physicians are isolated, volume based and mostly focus on all other diseases but MSK. By way of recommendation, he suggested that we refer back to the priorities that were identified from the Summit in 2004.

2.12 Canadian Health Services Research Foundation Workshop – An Organized Patient Voice for Primary Health Care

Hosted: CHSRF and PAC

Featuring: Martin Dawes, Abraham Fuks, Sholom Glouberman, Elke Grenzer

Moderator: Neil Stuart

This session represented the launching of the Patients Association of Canada (PAC). The goal of the association is to develop an organized patient advocacy voice. PAC is a patient governed and patient-led organization, which will seek to improve the experience of everyone in health care. Panelists discussed the involvement of patients in primary healthcare policy and practice, and provided some information about the direction of PAC.



At present, patients view communication and customer service in primary healthcare as lacking. Customer service means anticipating needs, delivering care with respect, acknowledging when things go wrong etc. Patients should be able to speak up and form questions about health system management, be empowered to ask questions, do research and be involved in courses of treatment. Patient-centered care needs to be *with* patients, and not something that is done *to* patients.

One main issue with respect to the lack of a patient voice may be that the '*squeaky wheel gets the grease*', and usually this is loudest from politicians, the media, or some other organized advocacy group. The panelists believe that having patient representatives on boards/committees within the system is a start, but that currently, these patients are mainly viewed as 'token' members of the group who lack real contribution. PAC wants to support patients who serve in these positions and provide them with resources to enable them to be powerful advocates on behalf of all patients. PAC identified that patient advocates are extremely important as patients are ill and in need. Another point of advocacy for the advancement of PAC is that patients in primary healthcare are often very complex, with many experiencing numerous co-morbidities. PAC will focus on the whole patient and provide an overarching voice. Currently, PAC is engaged in research and advocacy initiatives. It will assist and support patients who are sitting on hospital boards. PAC is also starting to work on a partnership with the OMA.

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