A Vision for 2017

In response to a request by Craig Knight at the Primary Care Workshop, and in the interests in making the suggestions which follow ‘live’, elements of a modernised Primary Care practice are suggested below.

Previous submissions to the Conversation on Health by the BC College of Family Physicians have already addressed Health Human Resources and the Primary Care system; this submission will not specifically address or duplicate those comments.

For context it is relevant to consider the current scope of the family physician Primary Care service contribution to BC. Typically over 84% of BC citizens see a family physician each year’, or (85% x 4.3M) 3,600,000 individuals cared for, with usually more than one visit and for more than one problem. This may represent the largest single source of direct service contacts supported by the provincial government for BC citizens.

This contribution will focus on the Primary Care system as staffed by family physicians and allied professionals in community settings (currently most commonly referred to as the ‘family doctor’s office’). It is proposed that these evolve – in fact, it is inevitable they will. Addressed herein are some speculations, and recommendations pertinent to providing leadership to a future which is more designed, more focused on planning for care, responsive in more ways, more aware of the processes underlying care and actively managing them, and in which Primary Care is much more integrated into the formal ‘system’.

In developing this contribution, it is well recognized, as was made clear by many contributors to the Conversation on Health, that the health care system is a relatively minor contributor to the overall health of a population. Far more fundamental are social and political policies which establish the socio-economic determinants, largely defining health and who has ‘more of it’ and who has less. These factors operate from preconception to death and are powerfully determinant of health, especially of the extremes of health. Only by addressing these factors can a society prevent degrees of ill health on a broad scale, and prevent development of issues which cannot be addressed other than marginally in the formal health care system. If the Conversation on Health were to do nothing more than lead to much more wise and bold social evolution, it would have succeeded marvelously. While current political rhetoric significantly evades touching on these issues so often raised in the process of the Conversation, pending evidence of the action phase, our view of the potential outcome remains optimistic.
Topic Areas

The various topics below do not stand alone; in fact, they beg for a comprehensive, integrated approach. They are separated for emphasis on domains which need to be actively considered, supported and addressed as we plan for a Primary Care future which serves BC best, 10 years from now.

Productivity

A system of one to one, face to face healthcare, with paper-based records, and largely paper and mail communication, and little differentiation of staff (FP and MOA), with major responsibility for monitoring progress and all responsibility for return visits resting on the shoulders of patients – often, naturally, ill and with little knowledge of health and their conditions – is inherently of low productivity. The recommendations which will follow are designed to contribute to increased productivity.

The BC College of Family Physicians recommends that all future planning for primary health care explicitly address consideration of productivity within the context of safety and effectiveness.

Technology

EMR use in Canada and in BC is almost uniquely low in terms of modern nations. While a process is underway to support the broader implementation of EMR’s in BC family physicians’ offices, there is no evidence that implementation per se will improve the delivery of Primary Care. The true value and outcomes such as noted below, will require active management, full team collaboration, a focus on measurement, use of the principles of clinical Microsystems and quality improvement, as follow below.

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- Patients are offered the alternative of communicating by telephone and (secure) email instead of office visits. Either patients or clinical providers might initiate health care interactions using these methods, or those below.

- Patients experience the potential benefits of a robust EMR, including:
  - Patient access to a practice website which includes:
    - Patient management of appointment bookings
    - Patient access to approved (by relevant health provider) laboratory, imaging, etc results

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1 Most citizens now have cell phones, with increasing capabilities; most homes have internet access and most patients use the internet for health information

2 A number of practices in BC are doing at least some of these; a number of EMR vendors offer some of these elements
Personalised information when logging on with information pertinent to the age/gender and health conditions of the patient

Patient ‘problem list’ accessible to other providers with patient provided permissions

Many patients will have their own health record on line, which may or may not link to their physician’s/s’ EMR(s)

- Automated reminders of pre-scheduled appointments by provider (any of the clinic staff or consultant referrals, etc) by automated calls to home phone, cell phone, text message, email, etc, as preferred by patient

- Automated reminders of follow-ups, including lab tests (with instructions), repeat imaging, next pap or mammogram, etc. These are often to be done before an appointment, enabling the encounter, by whatever means, to build on the information from the results.

It is recommended that the Primary Care Division of the Ministry of Health, in conjunction with other partners, develop an IT information ‘clearing house’, which can solicit information on novel resources and approaches, and actively disseminate ‘best practices’ to practitioners across the province. Acknowledgement of pioneers, documentation of business cases and processes and other methods of and supporting development should be used.

Collaboration/ Interdisciplinary Care

Primary health care is complex, belying its secondary position in the health care system. Efficiency, safety and effectiveness warrant engagement of a range of skills; reliance on family physicians as the sole clinical resource is outdated. The community practice of the future have a multidisciplinary team.

❖ A VISION

- Advanced Access for visits

- Preplanning for visits, to all/any provider(s) – involves a review of issues arising from past assessments, promotion/prevention/management issues due (now or shortly), prearrangement of tests, with results due for actual encounter; assignment of provider(s) according to needs; duration, nature of encounter related to needs/choices

- Tasks are analysed within the clinical team to ensure that, as far as efficiently and safely possible, each task is provided by the least ‘expensive’ provider with appropriate education, including a focus on upgrading education where practical, and enabling each provider to work at the higher level of their educational preparation

- Tasks are analysed within the clinical team to see when patient may manage tasks themselves, with a view to enhancing engagement in their care as well as efficient care
The patient population is analysed within the clinical team to assess and develop group visit opportunities.

Clinic engages representatives from all service domains to analyse results of care outcomes, patient input, efficiency measures, quality and safety measures and searches widely for examples of excellent practice with a view to constant improvement. Such teams meet weekly; report to the full clinic staff, who are also engaged in full staff meetings no less than monthly. All these activities are considered core work tasks/ responsibilities, not ‘sideline’ or ‘add-on’ work. The full clinic staff evaluate themselves as an organization (team) on how well they (together) achieved key clinical service goals. Workplace satisfaction is just as actively monitored and addressed as a key element of quality and outcome.

All of these are entirely technologically and economically possible; similar approaches/ components have the norm in a range of other domains in current Canadian and British Columbian experience. A barrier which needs to be addressed, both in BC and across the country is concerns (which significantly outstrip the reality) of liability.

*It is recommended that the Primary Care Division of the Ministry of Health support such innovations (often identified as the ‘expanded chronic care mode), through current activities (Practice Support Program), plus active direction and support to Health Authorities, development of funding streams for allied health and their infrastructure, recognition of exemplary practices, etc. A key stimulus for this is likely to be development of a Quality Outcomes Framework appropriate to BC and embedded in other elements identified in this and its companion documents.*

**Continuity**

A neglected area of the health care dynamic is ‘continuity’. Patients value continuity and in doing so, focus not only on the family physician, but on other members of the team, once familiar with them, as well as support staff, MOA’s, etc – they are known. Additionally there are key elements of continuity which need to be incorporated in understanding and implementation of system design and operationiv.

- Informational continuity
- Relational continuityv
- Management continuity

The available medical literature suggests that interpersonal continuity of care is associated with significant improvement in at least some care outcomes with the strongest evidence of such an association (being) for those outcomes that have been most frequently studied: preventive services and hospitalizationvii.

Experience has also shown, for example with ‘working down backlog’ in developing Advanced Access systems, that if such care is not done by the primary provider, about 1/3 of patients return to see their primary physician – an example of rework, nullifying the value of having a colleague assist in that process. Similarly, family physicians find many patients ‘checking’ after having seen a walk-in provider to confirm the diagnosis or approach – a source of waste and rework.
Informational continuity may assist in reducing repeat testing, and ensure follow-up on critical issues of health promotion, prevention or care.

Many health systems demonstrate their commitment to supporting continuity through rostering patients, whether this is in a capitated payment model (UK) or still a substantially FFS/blended model (Ontario FHT). The latter was a major change in a Canadian context, achieved with minimal ‘fuss’ – patients recognise and value continuity. The BC experiment with ‘virtual’ rostering led to high rates of continuity, with an economic incentive for educating patients, not dissimilar to the Ontario model.

The BCCFP recommends that all future planning for development of primary health care in BC explicitly focus on actively supporting continuity in care, in all domains.

Resourcing (Payment)

One of the barriers to the primary health care system we want and need is not simply the cost but the compartmentalization of healthcare funding; an issue creating barriers to innovation throughout the healthcare system. Essentially all payments for virtually the entire Primary Care “system” are made as payments for items of individual services by family physicians; comprising, for all of the below components, about 7% of the BC health care costs. These payments themselves are striking low considering the complexity of the health issues, and the level of education of the providers. In addition, these payments support:

- the facilities,
- all facility services (including telephone/heat/light/cleaning),
- all equipment,
- all staffing,
- all record keeping, including to date all and in future, at minimum 30% of information technology
- all pre- and post- services,
- after hours response (legislated) and
- the physicians taxes, leaving the balance as net income
- any infrastructure improvements are to be funded from this single resource
- the majority of professional registration, licensing and accredited Continuing Professional Development is included
- a substantial component of clinical teaching for medical undergraduates and postgraduates (and contributions to some other disciplines) – there is some university
payment, though minimal for clinical teaching, and the facility and staff infrastructures are supported by the physician’s office, staff, etc.

In support of this however, no other professional or agent can provide the service, no matter how capable, practical or efficient such service may be, nor can they (generally) be provided in other than a face-to-face manner. There is no incentive or alternative means to resource or benefit from any innovation of the kinds referenced above, or, for that matter, below.

Furthermore, as payments are made on an individual ‘doctor-patient’ basis, for ‘episodes’ of care, in a health system which espouses an ‘expanded chronic care’ approach, there lies (despite some recent, limited modifications) a fundamental discrepancy in approach. In addition, the funding model does not align itself well with approaches such as interprofessional care, clinical microsystems applications, complex clinical care (other than a few limited special fees), or health promotion or preventative health, or a broader Quality Outcomes framework or the IT resourcing and the fundamental office and other infrastructure elements likely to be required.

*It is recommended that the Ministry of Health, in conjunction with the Primary Care Division and Primary Care health organizations examine the financial requirements for the model health care delivery of the future, from the patient’s perspective. Key elements which must be addressed are the clinical infrastructure components, including staff, plus support for the continuing professional development of all workers – as individuals and as clinical teams, including support for formal teaching roles. Planning should take into account the other components of this report, and create financing models which can efficiently stimulate and support, in an evolving and responsive manner, a new future state – one designed to get the outcomes we want, not those we have.*

**Clinical Microsystems**

The Institute for Medicine’s report ‘The Quality Chasm’, addresses 4 ‘system levels’ at which change is needed. As summarized in Don Berwick’s article in Health Affairs, these are:

- **Level A**: the experience of patients and communities *(True North)*
- **Level B**: the functioning of small units of care delivery-Microsystems
- **Level C**: the functioning of the organizations that house or otherwise support microsystems
- **Level D**: the environment of policy, payment, or regulation, accreditation, etc.

Clinical Microsystems are a relatively new concept, but they have been described thoroughly in a new book. A range of resources have been available for years on the Clinical Microsystem website, whose ‘Green Book’ has provided a range of tools for “Assessing, Diagnosing and Treating (Your) Outpatient Primary Care Practice”. As stated in the ‘book’: “Clinical microsystems are the front-line units that provide most health care to most people. They are the places where patients, families and care teams meet. Microsystems also include support staff, processes, technology and recurring patterns of information, behaviour and results. Central to every clinical microsystem is the patient.

The microsystem is the place where:

- Care is made
• Quality, safety, reliability, efficiency and innovation are made
• Staff morale and patient satisfaction are made

Microsystems are the building blocks that form practices. The quality of care can be no better than the quality produced by the small systems that come together to provide care."

The concept of the Microsystem and the development of processes to use the concept as a organising principle for change and for quality: "All health care professionals—and we believe all front line clinical and support staff are professionals—have 2 jobs. Job 1 is to provide care. Job 2 is to improve care."\textsuperscript{xvi}

It is recommended that future planning for Primary Care use advanced models for the health care system including the ‘Results-based Logic Model for Primary Care’\textsuperscript{xiii}, and the Clinical Microsystems model as organising frameworks. The latter has a great number of tools and management approaches directly relevant to care and care management. Goal s (including ‘quality’), management systems and payment modalities are only some of the components of the “Inputs” necessary to support patients in achieving improved health.

Quality

Quality is referenced 26 times in the Primary Care Charter, either as Quality of Life (8 times) or Quality Improvement (10 times) or in relation to Quality Care (8 times). Despite its importance, no specific programs, incentives or monitoring address Quality in primary care in BC.

The Crossing the Quality Chasm\textsuperscript{xiii} report highlighted 6 ‘Aims for Improvement’ – which can be seen as part of the framework for quality:

1 Safety: Patients are to be as safe in healthcare facilities as they are in their own homes
2 Effectiveness: The health care system should match care to science, avoiding both overuse of ineffective care and under use of effective care
3 Patient-centeredness: Healthcare should honour the individual patient, respecting the patients choices, culture, social context and specific needs
4 Timeliness: Care should continually reduce waiting times and delays for both patients and those who give care
5 Efficiency: The reduction of waste and thus the total cost of care, for example, waste of supplies, equipment, space, capital, ideas and human spirit
6 Equity: The systems should seek to close racial and ethnic gaps in health status.

The elements which contribute to quality are many and complex, but, in the Canadian context, they have been addressed in the family practice setting through the Quality in Family Practice project in Ontario\textsuperscript{xiv}. Elements of the professional components have been outlined in pictorial format in the Quality Tartan\textsuperscript{xv} and the Quality Cube\textsuperscript{xvi}. There are system, procedural, physical, policy as well as care elements to quality in a practice. A few pilot practices have taken on the challenge of engaging in what is in essence an ‘accreditation’ process in primary care, and, as with hospitals, the key aspect is self assessment, learning and change. Other health systems have entrenched .
The United Kingdom, through the Royal College of General Practitioners has its Quality Team Development\textsuperscript{xviii}. QTD functions by:

- Engaging all members of the practice team in clinical governance
- Identifying those things the practice does well and prioritise areas for improvement
- Supporting practice teams in finding solutions and improving the quality of their service
- Providing a firm basis for practice development planning
- Supporting achievement of the Quality and Outcome Framework
- Providing a framework for reviewing practice roles and structures
- Improving team morale
- Acting as a catalyst for change

There is also available the Quality Practice Award\textsuperscript{xviii}, a voluntary process, on which the Ontario model was developed, and like it, takes up to 18 months to complete.

\textit{It is recommended that the Ministry of Health, through its Primary Care Division, work with the BC College of Family Physicians and other groups to develop a BC Quality Outcomes Framework, followed by the institution of pilot programs for assessing and recognizing quality in practices, with a view to raising the profile of the elements of quality, acknowledging those who have committed to addressing quality and meeting defined standards, as with Accreditation in other health sectors.}

\textbf{Measurement}

It has been said, repeatedly, that ‘if you can’t measure it, you can’t manage it’. Primary Care suffers from a major dearth of measurement – “Canada lacks the most basic ability to measure and monitor our PHC system\textsuperscript{xix}”. The reasons are many, including a major lack of IT infrastructure in Primary Care, dependence on a FFS payment system which reinforces an episodic approach to care, rather than a population base, and lack of a standardization in data terminology, aggravated by a dependence on a disease nomenclature which is inappropriate for Primary Care (ICD-9 & 10). As the amount of alternative funding grows in British Columbia, the completeness of fee-for-services (FFS) data as a source of population-based information decreases\textsuperscript{x}. The Canadian Institute for Health Information has developed a set of 105 PHC indicators and standardized indicator definitions\textsuperscript{xxi}.

Measurement is a tool for all four system levels in health care:

- Patients can use measurement to self-manage components of their own care – they need the tools and education to do so
- Practices need measurement to know who they are serving, who is receiving care and who not, and who has achieved health (promotion, prevention, treatment) goals and who not, how long care takes, what it is costing, how patients perceive care, etc
- Health organizations need measurement for most of the same needs, ‘rolled up’, and for assessing where needs are within their domain of responsibility
- Health systems need measurement at a similar congregate level, for broader policy and outcome analysis and planning.

Measurement generally does not ‘just happen’ – as noted above, it generally \textit{doesn’t} happen. It needs stimulus and support. Tools are needed; ideally those which can capture data of relevance in the course of activity, with a minimum of additional work. A change from the historical approach to managing
primary care, the system ‘perfectly designed to get the results it is getting’, requires human resource support to:

- integrate new approaches to work in primary care practices
- support for a new understanding of measurement relevance and process and
- support for the development and integration into practice of the active collection of a comprehensive range of measurements.

It is not surprising that the limited data collected in Primary Care in BC, as in many other domains of life, reflect where we put our emphasis. Our current system of care evolved in a manner which made managing billing of key interest. Our new interest, at least in rhetoric, is quality of care, including comprehensive management of chronic diseases. We know this requires information – indeed, health care is evolving from a knowledge industry (where physicians had the knowledge), to a dynamic ‘information management’ industry, in which information is changing daily and a key professional role is converting this to relevant knowledge to apply to health care – at the individual patient level, the populations of patients (e.g. ‘registries’) and the organization. Hence the challenge to now invest anew in measurement for other purposes than billing. The needs are fundamentally different and reliance on data as billing ‘by-product’ is as relevant as relying on other ‘by-products’ as unrefined consumables.

Other jurisdictions have developed robust and flexible systems of measurement of Primary Care information at a system level, such as the BEACH system in Australia. The BEACH program continuously collects information about the

- patients seen
- reasons people seek medical care
- problems managed
- treatments provided

in general practice in Australia. It uses a cross-sectional, paper based data collection system developed over the past twenty-seven years at the University of Sydney. Data generated is used by researchers, government, industry and non-government organisations.

It is recommended that BC promptly develop standards for Primary Care health information and reporting, in addition to IT standards, using a coding system such as ICPC. Development should include interested parties such as representatives of primary care health organizations in BC, along with CIHI, CHSPR and the Primary Care Division of the Ministry. The process should include the development, testing and refinement of systems, including reporting systems, which are fully adequate to sufficiently answer the care, development and reporting needs of primary care in BC.

**Governance**

Governance is perhaps one of the most contentious issues in the evolution of primary care. The historical model of family practice had advantages. It offered much freedom for physicians: clinical freedom, freedom of styles of practice and hours of service, freedom from the need to negotiate – though now many of these are as limiting as liberating. Some gradual collocation is occurring. Historically family physicians collaborated in after hours care, but with the breakdown of family physician involvement in hospitals, this has started to erode. Some family physicians joined together, or joined to work in ‘walk-in’ clinics, chiefly on a fee sharing basis, but focusing on simple short-term,
episodic health issues. Others have worked on a contract basis with Health Authorities, either in community clinics, or, increasingly in hospitals as ‘hospitalists’.

The current reality of (largely) independent, often solo family physicians, operating chiefly with one non-clinical office support, entirely supported by the physician’s FFS clinical income is not perceived as adequate to address the health care needs of BC. In substantial part this is due to the efficiency of combining workers, even in the case of the intimate nature of family practice. In part this is because that care is also changing, as noted above. There is a need for a sophisticated IT infrastructure. There is a desirability of interprofessional care. There is a relative reluctance to establish new clinical ‘businesses’ on the old model by young practitioners – due to financial, work style and life style issues.

Some early contracts between community societies and the Ministry of Health reflected one governance model. The Federal government’s Primary Care Demonstration Projects in the late 90’s led to some further experience with contracting with physician groups, including challenges to develop internal governance models to address income distribution (payment was a single monthly ‘group’ payment) and the addition of other professionals in the clinical team, outside a formal health organization.

The Primary Health Care Transition Fund contributed to development of primary care offices in the newly reconstituted Health Authorities. These began to develop connections with community-based primary health care clinicians, developing some contracts for novel activities.

Elsewhere in Canada, more complex needs for Governance developed in Ontario, firstly with the joining together of family physicians in Family Health Networks, then Family Health Groups and more recently, and much more complexly, Family Health Teams. These latter included, variously, a range of independent family practices, other community providers, including independent professionals (physiotherapy, psychologists, etc), local health services (including speech and language, mental health, etc), municipalities, etc. Payments were single comprehensive payments and novel structures and contracts needed to be evolved, often quickly (see ‘Governance’ in the Primary Care Toolkitxxiv).

Movement to similar community-based primary health care interprofessional services, with models, resourcing, and approaches such as those elaborated on earlier, will require new funding approaches, and new governance models. These offer hope to draw in young providers of all disciplines, desiring personal and family flexibility in their careers, flexibility in a challenging real estate environment, new interprofessional opportunities within an uncertain liability environment, opportunities for significant clinical evolution with new infrastructure needs not well addressed in current models, etc.

*It is recommended that, along with exploration of more functional funding models, that the Ministry of Health work with Primary Care organizations to develop robust effective governance models to share with the practicing community and to offer as companion elements in implementing the changes canvassed in this document.*

**Conclusion**
The BC College of Family Physicians is pleased to have had an opportunity to contribute to the Conversation on Health. We hope that the action plan arising from this process will demonstrate a strong vision for a future which focuses on patients’ needs and their safety. In developing the action plan, we hope that the various components of the change BC citizens deserve, as touched on above, will inform the process and be addressed in clearly observable manner, first in planning and shortly thereafter in the experience of primary health care providers across the province.

Thank you

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ii Linder JA, Ma J et al Electronic Health Record Use and the Quality of Ambulatory Care in the United States. Arch Int Med 2007;167:1400-1405


iv Reid RJ, Haggerty J, McKendry R Defusing the Confusion: Concepts and Measures of Continuity of Healthcare CHSRF Mar2002


vii Berwick D “A User’s Manual for the IOM’s ‘Quality Chasm’ Report” Health Affairs 21(3); May/Jun 2002: 80-90

viii Quality By Design: A Clinical Microsystems Approach Eugene C. Nelson (Editor), Paul B. Batalden (Editor), Marjorie M. Godfrey (Editor) Jossey Bass: March 2007


x [http://cms.dartmouth.edu/gbook/OPPC/OPPC%20Primary%20Care.doc](http://cms.dartmouth.edu/gbook/OPPC/OPPC%20Primary%20Care.doc)

xi Ibid; page 3


xv [http://www.qualityinfamilypractice.com/about_project/models/tartan](http://www.qualityinfamilypractice.com/about_project/models/tartan)

xvi [http://www.qualityinfamilypractice.com/about_project/models/cube](http://www.qualityinfamilypractice.com/about_project/models/cube)
xvii http://www.rcgp.org.uk/quality_/quality_home/qtd.aspx

xviii http://www.rcgp.org.uk/continuing_the_gp_journey/team_quality/qpa.aspx


xx http://www.chspr.ubc.ca/research/phc/provider/physician


