It is a well-known axiom that one attracts more flies with honey than vinegar. Nowhere has this approach been taken more to heart than in the past decade of primary care policy in Canada.

- Danielle Martin, pg. 34

Framework for Advancing Improvement in Primary Care

Nick Kates, Brian Hutchison, Patricia O’Brien, Brenda Fraser, Susan Wheeler and Cheryl Chapman

Commentary from Bonnie Brossart, Lauren Donnelly, Stephen Duckett, Philip Ellison, James MacKillop, Danielle Martin, John Millar, Terrence Montague, Joanna Nemis-White and Stephen Peckham

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Cover Illustration: Taylor Addams, Vancouver, British Columbia
Few people would dispute the claim that primary care is the beating heart of healthcare systems the world over. One of the clearest signs of its importance is the vast catalogue, pumped out over the last 20 years, of governmental and para-governmental reports, scholarly studies and expert reviews opining on primary care’s essential attributes, analyzing its current shortcomings and making recommendations for its transformation. The World Health Organization (WHO nd), for example, says that advancing primary care requires increasing “stakeholder participation” and undertaking reforms in the following four areas:

- Universal coverage
- Service delivery
- Public policy
- Leadership

These reforms are explained at length in the WHO’s report *Primary Health Care – Now More than Ever* (2008), which places special emphasis on achieving “people-centred” care.

Nearer to home, the Canadian Health Services Research Foundation (CHSRF) recently published a study illustrating the economic benefits from improving primary care (Dahrouge et al. 2012) across the country. While the focus of this report is on the financial impact of various system improvements, the authors’ call for “strategic national investments” is predicated on the fact that primary care services in Canada are “of moderate technical quality” and “poorly accessible” (2012: 6). As if anticipation of several of the findings in this report, a number of Canadian jurisdictions have already taken steps to reinvent their primary care systems. In Alberta, for instance, a “trilateral governance” model based on devolving local decision-making to primary care physicians seems to be paying health dividends for patients (Ludwick 2011; see also Brossart and Donnelly’s report on Saskatchewan’s initiative described in this issue).

**Lead paper**

In this issue of *HealthcarePapers* we are pleased to bring you an original essay that furthers this important conversation. Working under the aegis of Ontario’s Quality Improvement and Innovation Partnership (QIIP), which is now part of Health Quality Ontario, Nick Kates and his five co-authors designed a framework they believe will be useful “to guide primary care improvement.” Drawing on the extensive body of Canadian and global primary care-reform research and experience, Kates et al. present a three-layer framework that lays out the main features of high-performing primary care and the “supports” required to attain it.

Kates et al.’s guiding premise is that “systems of care” must be re-organized. The framework they propose to direct that work is closely aligned with the Institute...
for Healthcare Improvement’s Triple Aim approach to outcomes and the Institute of Medicine’s six improvement aims. Working within those theoretical parameters, when it comes to actual interventions, Kates et al. emphasize, not unlike the WHO and CHSRF reports I touched on earlier, the centrality of “well-functioning teams that use proven quality improvement methods, effective information management systems and external resources and support to implement these changes.”

At the hub of their framework is patient-centred, family-centred and community-centred care. Kates et al. contend that the following six characteristics “contribute to the overall quality of the care being delivered” to each of those constituencies:

- A population focus
- Patient engagement
- Partnerships with other health and community services
- Team-based care
- Performance measurement and quality improvement
- Innovation

The authors anatomicize each characteristic in turn, thus providing a basis on which to launch the second part of their paper: a discussion of four “forms of direct support … required to enable practice-level transformation.” Insights into the importance of staff learning, tools and resources, support for quality improvement and innovation dissemination then pave the way for a concluding section briefly outlining 10 system-level policies and structures that, Kates et al. argue, provide the necessary context if we are to accomplish practice-level reforms. Each of these complex facets of a “sustainable” and “supportive” system – for example, measurable goals, policy and funding support for inter-professional teams, mechanisms to support coordination and integration and adequate funding – could easily serve as the basis of at least its own article.

Commentaries

Arguing from a systems theory standpoint, Philip Ellison notes that Canada’s primary care sector “remains frustrating in its seeming isolation from other elements of healthcare, both horizontally and vertically.” In order to move forward, he posits, we must build “primary care infrastructures that facilitate and support system integration.” In this regard, the necessary condition for quality improvement is thorough “information system implementation,” the lack of which currently constrains family physicians.

The Health Quality Ontario framework would, Ellison argues, be useful for carrying out such work because it “stimulates systems thinking in an ecological context.” Ellison makes, however, two important adjustments. First, he urges a shift away from “such dependency-laden terminology such as care of patients, to relations with our practice citizens.” More than mere semantics, this change would help to foster “true partnerships between equals.” Second, I find especially intriguing his call to move from the Triple Aim’s focus on “patient care” to a broader concern with “health.”

In his commentary, Stephen Duckett offers a somewhat more ground-level analysis. Agreeing with Kates et al. that “system-level enablers are the sine qua non of primary healthcare reform,” he emphasizes offering “the right (financial) incentives” to providers.
The ongoing dominance of fee-for-service remuneration is, in Duckett’s view, a major stumbling block to progress. In order to strengthen the utility of their framework, Duckett counsels, Kates et al. need to include such politicized system-level enablers right in their model. Only thus will their framework have the clarity and muscle to be of real use to political and system leaders.

Concerned primarily with implementation, Danielle Martin argues that, “for a framework for change to be meaningful, it must infiltrate day-to-day work in the system.” While Duckett recommends system-level enablers, Danielle Martin trains her gaze on policy tools as a way to breathe life into Kates et al.’s “ideal state” framework. According to Martin, the new elements that Kates et al. add to the longstanding discussion of primary care are the importance of team-based care and performance measurement/quality improvement. But without the yielding of “authority” (e.g., by governments and regulatory colleges) and “symbolic and hortatory tools” owned and actualized by the healthcare workforce itself, Martin sees little hope of renewing primary care along the lines Kates et al. aspire.

The next commentary presents a “complementary” framework for community-oriented primary healthcare (COPHC) services. Delineating six evidence-based requirements for COPHC, John Millar argues for their role in addressing health inequities, a major element in Kates et al.’s model. Millar diverges from the lead authors’ vision of data collection, however, in his emphasis on a population approach and collaborations among public health, community services and social agencies. One of the boons of such collaborations would, Millar argues, be a more effective use of additional funds invested in primary prevention and public health.

The literal and spiritual home of Canada’s medicare system, Saskatchewan holds a special place in health-planners’ and scholars’ bosoms. Bonnie Brossart and Lauren Donnelly’s commentary takes us inside that province’s Primary Health Care Framework, which was released in early 2012 and “validates” much of Kates et al.’s approach. A belief in the fundamental importance of relationships – among health providers and health-services users, their communities and health-delivery organizations – is key to understanding Saskatchewan’s approach. As well, similar to Kates et al.’s framework, Saskatchewan built in a focus on “continuous improvement capability” tied to clear expectations and accountabilities. As other commentators in this issue have noted, quality improvement is no easy feat, often because the main players lack the requisite skills and knowledge to manage and lead change (on family physicians’ shortcomings in this regard, see Ellison). I admire the confidence and courage of Saskatchewan’s health leaders, and it might just be that the broad consensus involved in establishing that province’s framework will be enough to carry the day.

From the west we now travel east, to Nova Scotia. Drawing insights from ICONS, that province’s approach to managing acute and chronic cardiac diseases. Joanna Nemis-White, James MacKillop and Terrence Montague concur with Kates et al. on the critical role of integrated care (i.e., community-based, multi-professional teams) in abetting population health. I was struck, however, by the authors’ analysis of the “care gaps” that persisted despite the application of ICONS’ principles, as well as their illumination of the “striking variance
among practitioners in the valuing of specific characteristics of successful team care.” Finally, in an intriguing thematic overlap with Millar’s commentary, the authors convincingly recount the disabling disconnect between patients’, caregivers’ and non-governmental organizations’ support for integration versus the government’s lacklustre resolve to make it happen.

Our final commentary is by Stephen Peckham, who, drawing in part on examples from the United Kingdom, argues that successfully improving primary care requires that “the direction of travel must be mapped out.” While Peckham sees much to admire in Kates et al.’s framework, he also notes that their “useful first step” lacks “continuity of care” as a care-quality indicator, and he wonders at length about what the placement of “community” at the model’s centre means “in practice.” Overlapping with that latter point, Peckham sees a “confusion” in Kates et al. between “concept” and “practice.” Primary care is, he argues, “context specific”; therefore, he advises more attention be paid to understanding how to organize and deliver care, as well as how policy- and decision-makers ought to “structure” organizational models, payment and incentivizing systems and accountability structures – a concern voiced in several of the other commentaries as well.

“There is no disputing that the key to any high-performing healthcare system is a high-performing primary care system,” observe Brossart and Donnelly. While there are still many factors to be investigated and adjustments to the framework to be made, all our commentators agree that Kates et al. developed a tool that will prove useful for grinding that key and then fitting it into the lock.

Peggy Leatt, PhD
Editor-in-Chief

References


INVITED ESSAY

Healthcare Papers
Framework for Advancing Improvement in Primary Care

INVITED ESSAY

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ABSTRACT
A consistent feature of effective healthcare delivery systems is a strong and well-integrated primary care sector. This paper presents a framework that describes the key elements of high-performing primary care and the supports required to attain it. The framework was developed by the Quality Improvement and Innovation Partnership in Ontario (now part of Health Quality Ontario) to guide the process
As health systems evolve, there is increasing recognition that primary care is the foundation of a high-performing healthcare delivery system. An effective primary care system should be comprehensive (Starfield et al. 2005), be the first point of contact that patients have with the care system and serve as the place where care is initiated and coordinated (McMurchy 2010; Starfield 2009). Primary care offers opportunities for early detection and secondary prevention (Ferrante et al. 2000; Roetzheim et al. 2008; Starfield et al. 2005), the reduction of avoidable emergency department visits and hospitalizations (Hurley et al. 1988; Spann 2004), decreasing costs and increasing efficiencies (De Maeseneer et al. 2003; Ferrante et al. 2000; Ferrer et al. 2005), the reduction of health disparities (Bindman et al. 1995; Katz et al. 2010; Shi et al. 2002) and the improvement of the health and well-being of individuals with chronic diseases (Bindman et al. 1995), all within an environment that is familiar, comfortable and accessible for patients.

To take advantage of these opportunities, primary care practices must be able to address the needs of populations as well as individuals, and deliver care that is proactive and patient, family and community centred (McMurchy 2010). Primary care practices must have an overall goal of achieving the Institute for Healthcare Improvement (IHI) Triple Aim of (1) improving the health of the population (better health), (2) improving the patient experience of care (better care) and (3) reducing waste and reducing, or at least controlling, the per capita cost of care (better value) – and doing all of these simultaneously (IHI 2012). Table 1 shows how the Triple Aim links to the six improvement aims identified by the Institute of Medicine (Committee on Quality of Health Care in America 2001).

Creating primary care practices that can deliver high-quality care requires changes in the way that systems of care are organized. This includes well-functioning teams that
use proven quality improvement methods, effective information management systems, and external resources and support to implement these changes.

It is helpful to conceptualize these changes within a framework designed to guide primary care improvement. This paper presents one such framework that has been developed by the Quality Improvement and Innovation Partnership (QIIP) in Ontario. (QIIP was established by the Ontario Ministry of Health and Long Term Care in January 2007 and became an incorporated non-profit organization in February 2009. One of its roles was to assist primary care practices in Ontario to introduce quality improvement methods and approaches. In April 2011, QIIP became part of Health Quality Ontario.) It outlines the framework and its three components, including the characteristics of high-performing (transformed) primary care organizations. It then proposes strategies to assist primary care practices to implement these characteristics, and summarizes external (system) supports required to enable the transformation.

The Framework

The framework has three components (Figure 1):

1. At its core are patients, their families and the communities in which they live.
2. Surrounding that core is a ring representing the six key characteristics of a transformed model of primary care.
3. The lower part of the framework depicts the desired outcomes: the three domains of IHI’s Triple Aim.

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<thead>
<tr>
<th>Attribute</th>
<th>Population Health</th>
<th>Patient Experience</th>
<th>Per Capita Health Cost</th>
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<tbody>
<tr>
<td>Safety</td>
<td>X</td>
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<td>Effectiveness</td>
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<td>Efficiency</td>
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*As defined by the Institute of Medicine (Committee on Quality of Health Care in America 2001).

Patient, Family and Community-Centred Care

At the centre of the system are individuals, their families and the communities in which they live. While it is almost a cliché to state that care must be responsive to, and driven by, the needs of the individual patient, the transition to patient-centred care requires shifts in attitudes, culture and working relationships among healthcare providers. They need to view healthcare through the eyes of the patients and their families and understand their experience during the patients’ journey through the healthcare system. Providers must be willing to listen to what patients report about the care they are receiving and to engage patients in the design, delivery and evaluation of services, while eliminating activities and services that add no value for patients or their families. This kind of care requires strong partnerships between patients and providers who respect, assist and support patients and families as decisions are made about their health and healthcare, and who provide them with the information and tools they need to better manage their health issues.

Family-centred care recognizes that individuals live within families and other informal support systems that can play many different roles in illness care and in promoting
Framework for Advancing Improvement in Primary Care

Figure 1. Quality Improvement and Innovation Partnership Improvement Framework

**PRIMARY CARE**

- Population Approach
- Partnerships
- Patient Engagement
- Innovation
- Team-Based Care
- Measurement & Improvement
- More Efficient Use of Resources
- Healthier Populations
- Improved Patient & Care Team Experience
- Patients
- Families
- Communities

health. Families support, encourage and assist the coordination and management of various aspects of care, including navigation through the healthcare system. Engaging families and providing them with information and support can facilitate these activities and complement primary care services. However, families can also have a negative impact on care, either by failing to provide these resources or through criticism or unhelpful advice that may undermine patients’ attempts to manage their own conditions. Involving families may address these issues and help family members become more responsive to their relative’s needs. Family members may also need support or assistance when they become caregivers for ailing relatives.

Communities also have an impact on the health of the people (populations) who live within them. A healthy community can provide benefits that reduce the negative effects of social and environmental health determinants and build resilience among its members. It can also offer a variety of formal and informal services and supports, which are an integral part of effective primary care, especially if they are well linked and coordinated.

**Six Characteristics of High-Performing Primary Care Practices**

The following six characteristics are central to high-performing primary care practices and together contribute to the overall quality of the care being delivered:

1. A population focus
2. Patient engagement
3. Partnerships with other health and community services
4. Team-based care
5. Performance measurement and quality improvement
6. Innovation

Examples of the applications of these six characteristics are presented in Table 2.

**A Population Focus**

A population approach aims to maintain and improve the health of a practice’s entire population.
population and to reduce inequities between different subpopulations (Lynn et al. 2007). It requires the systematic collection of information about the health and socio-demographic characteristics of the practice population, and the ability to consider and monitor the well-being of that population as a whole, rather than just those individuals who seek care. Population-focused care is significantly facilitated by effective information technology (IT), which enables a practice to create a comprehensive list of patients, that can be used to monitor the care of individuals with chronic conditions on a regular basis and to identify groups that are at risk or that may benefit from specific preventive or disease management interventions.

The ability to track everyone in a practice population and in population subgroups (e.g., people with specific illnesses or care needs) over time supports proactive care and enables a practice to reach out to those who might not otherwise be seen. It also supports “planned” visits, with a team that is well-prepared to meet an individual’s needs at every visit (Wagner 1998). This population approach is a first step toward another goal of primary care transformation – an emphasis on prevention and early detection. One example would be an 18-month well-baby visit followed by proactive monitoring of the progress of all children in a cohort born in the same year, to ensure that those children identified as being at risk are linked with the resources they need. For those with chronic

<table>
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<tr>
<th>Characteristic</th>
<th>Application</th>
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<tbody>
<tr>
<td>Population focus</td>
<td>Registry to track individuals with a specific health condition or multiple chronic conditions. Mail or telephone reminders for patients who are overdue for preventive care.</td>
</tr>
<tr>
<td>Patient engagement</td>
<td>Development of a care plan in partnership with the patient. Focus groups with patients to learn how care could be improved. Inclusion of self-management support and patient goal setting at every encounter and in every care plan.</td>
</tr>
<tr>
<td>Partnerships</td>
<td>Weekly visits to primary care practices by medical specialists. Full- or part-time secondment of staff from community agencies to work within a primary care setting. Development of collaborative programs, such as an exercise program for overweight children.</td>
</tr>
<tr>
<td>Team-based care</td>
<td>Allocation of tasks according to a clinician’s skill set and scope of practice rather than discipline. Daily team huddles. Allocation of tasks among team members prior to a patient’s visit.</td>
</tr>
<tr>
<td>Innovation</td>
<td>Day-of-choice access. New ways of providing care such as telephone visits. E-mail communication with patients. Group medical visits.</td>
</tr>
<tr>
<td>Use of measurement and improvement methods</td>
<td>Review of practice data to understand the needs of populations being served. Mapping of office processes to identify improvement opportunities. Routine use of the Model for Improvement and Plan-Do-Study-Act (PDSA) cycles to test small rapid changes.</td>
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conditions, for whom most of their treatment occurs within primary care, this increases the likelihood of preventing relapses and of intervening earlier when symptoms worsen, thereby lessening the need to use secondary or tertiary services and reducing emergency department visits and hospitalizations.

**Patient Engagement**

Patient engagement refers to “actions individuals must take to obtain the greatest benefit from the healthcare services available to them” (Centre for Advancing Health 2010: 2), rather than the actions of professionals or the policies of a care setting. Patients need to be active partners in their own care and in the planning and organization of services in the practice they attend.

At the clinical level, patients need (1) a plan that reflects their goals; (2) easy access to copies of all relevant information about their health problems and treatment, including their health record; and (3) tools and resources that are comprehensible (health literacy), culturally appropriate and easy to implement so that they can better manage their own healthcare when they are not in direct contact with a health professional.

At the practice level, patient engagement means ensuring patients’ are considered partners in planning services and designing the way the practice operates. Providers need to understand how services function from the perspective of the patients as they move through the system, and proactively seek out and listen to feedback from patients about how services could be improved. This can be accomplished by “mapping” the patient’s journey through the system, organizing focus groups of patients and family members, conducting individual interviews and carrying out surveys that include open-ended questions about patients’ experience of care.

An understanding of individuals’ experiences and journeys when seeking healthcare can also be a useful way of identifying areas in which a practice is underperforming. The patient experience can then be used to redesign these services; this redesign is referred to as “experience-based design” (National Health Service Institute for Innovation and Improvement 2012).

**Partnerships**

Primary care does not exist in isolation. It needs to be well linked and integrated with other health and social services to ensure a smooth transition and an efficient exchange of information when an individual is referred to another service (Kilo and Wasson 2010). The same applies to community services and programs that offer resources that enhance and complement those that can be provided in the primary care setting. These inter-relationships can be depicted schematically (Figure 2).

Linkages with hospitals, community specialists and public health services can also be facilitated by the integration of specialists (physicians and specialists in other disciplines) and programs into primary care settings. This integration can improve access to these resources, increase the skills and capabilities of primary care providers and provide opportunities to discuss cases that might not otherwise have access to specialist expertise. Ideally, these linkages are based on collaborative partnerships between providers, with each contributing services that are complementary, and the responsibilities for care being shared.

Two key ingredients of collaborative partnerships are effective and regular communication (particularly between hospitals and primary care) and an emphasis on smoothing transitions between services. The more effective these partnerships are, the less the need for more expensive secondary or tertiary services is likely to be. Effective partnerships can also reduce hospitalizations rates and
visits to emergency departments. Efficient and well-linked information systems play an important role in the rapid exchange of information and communication between primary care and specialized services.

Partnerships with local agencies can keep a practice informed about services in a community and help patients to access programs that may be beneficial. These partnerships can address significant lifestyle issues that contribute to health problems, including chronic diseases, where resources available in the community can complement those available in the practice. They can also lead to joint programs that can be offered either in the primary care setting or at a community location, and offer opportunities for agency staff to pay regular visits to the primary care practice or to co-locate some of their staff or services. Attachment of staff of community agencies (e.g., home care, public health) to primary care practices can significantly improve coordination and access to appropriate services for patients. Community linkages also enable primary care providers to address broader determinants of health as part of a network of health and social services.

**Team-Based Care**

Providing the range of primary care services needed by a practice population usually requires more than just a single practitioner working on his/her own. The practice team can include not only the family physician,
practice nurse and receptionist or medical office assistant (often the core team in a primary care practice) but also professionals from a variety of disciplines. For example, it is increasingly common for nurse practitioners, physician assistants, mental health therapists, dietitians, pharmacists, psychiatrists, internists, occupational therapists, physiotherapists and social workers to be working in primary care practices (Kates et al. 2002). All team members need to be able to work to their full scope of practice, be aware of each other’s roles, communicate with each other clearly and regularly and coordinate their activities in a timely fashion. A team may also be established within a practice to serve a specific purpose – a quality improvement team, for example, may take on particular tasks related to improving the quality of care within a practice.

Team-based care is characterized by a shared vision and purpose, collaborative practice and shared clinical decision-making. To maximize a team’s potential, responsibilities need to be apportioned according to the needs of the population being served, rather than solely on the basis of traditional scopes of practice. Many of the functions of team members in primary care – panel management, care coordination, health education and promotion, health coaching and case management – can be carried out by a number of different disciplines and should be addressed by matching the skills of each team member with the tasks that need to be performed. The family physician can then focus on what she is uniquely qualified to do and provide consultations as needed to the rest of the team (Bodenheimer and Grumbach 2006).

Performance Measurement and Quality Improvement

Providers have two jobs: to do their work and to improve their work. Quality improvement needs to become an integral part of the culture and daily activities of primary care; performance measurement is an essential driver of change and quality improvement (Martin et al. 2007).

While it is almost a cliché to state that care must be responsive to, and driven by, the needs of the individual patient, the transition to patient-centred care requires shifts in attitudes, culture and working relationships among healthcare providers.

Together with the IHI Triple Aim, the following improvement aims, as described by the Institute of Medicine (Committee on Quality of Health Care in America 2001), provide a framework for performance measurement and quality improvement efforts:

- **Person- and family-centred care:** Everything that a system does should add value to the care an individual receives, or to his or her experience of seeking and receiving care. System redesign needs to be built upon an awareness of the patient journey through the system, which can highlight opportunities for improving this experience.
- **Equitable care:** Resources must be distributed fairly and evenly across the system, according to need, with priority given to the most disadvantaged individuals/populations. Equity must apply to outcomes as well as to access to and use of services.
- **Safe care:** High-performing systems must avoid doing anything that will have a negative impact on an individual’s well-being. Preventable factors that can undermine an
individual’s safety include poor communication between providers or systems, a lack of clarity in medication instructions, the patient not being aware of or given a copy of his care plan and delays in accessing services or arriving at a diagnosis. Wherever possible, care should also be error free.
When errors do occur, they need to be identified and corrected as they arise and measures taken to prevent them from recurring.

- **Efficient care:** Waste can take many forms, such as time spent by providers searching for necessary reports or forms during a visit, or by patients waiting to be seen; the repetition of processes; the underutilization of resources; and a lack of preparation for patients’ visits. Efficient care eliminates activities that do not add direct value to individuals’ experiences and optimizes the contributions of all members of the healthcare delivery team.

- **Effective care:** Care that is effective is informed by the best available evidence and uses data to measure and drive improvement. Data being collected need to be relevant and used on a continuing basis for improving care and supported by effective information management systems.

- **Timely care:** Individuals should be able to access the services they need with a minimum of inconvenience and without facing unnecessary obstacles, ideally on their day of choice. Timely access enables early intervention during an episode of illness.

Primary care staff need to continually search for ways to improve the care they deliver and use time and resources more efficiently, employing proven improvement methods such as the Model for Improvement (Langley et al. 1992) to identify improvement opportunities and rapidly test and implement small changes in a cumulative fashion. Once a team has determined the overall aim of an improvement activity, the next step is to learn how the practice and team are currently functioning; the needs – met and unmet – of the populations being served; the experiences of people using the services; and the gap between current and desired practices. Simple tools can be employed to gather baseline data and identify where there are opportunities for improvement. Desired improvements can be tested using Plan-Do-Study-Act (PDSA) rapid cycle tests of change (Shewhart 1980). Successful improvements can then be spread to other parts of a practice or to other clinical problems. This process can be facilitated by external coaches (Knox et al. 2011), who can support teams to apply and integrate quality improvement methods.

Measurement is critical to determining whether changes are actually improvements. Gathering baseline data identifies where systems are underperforming; this can further define improvement opportunities. Measuring the impact of all changes being introduced is essential to determining whether they achieve their aims. Effective IT systems allow clinical data to be tapped to review a team’s performance and identify opportunities for introducing changes. Data need to serve a purpose. There is no rationale for collecting data that does not meet the planning, accountability, evaluation or improvement needs of the practice.

Practices also need to consider how to sustain the improvements they have made and how to spread successful changes to other
populations and problems. This can be challenging, especially if the focus of a practice shifts to other areas, or a key staff member leaves or changes responsibilities. As much as possible, successful improvements need to be built into the day-to-day functioning of a practice. A strategy for holding the gains – sustaining the improvement over time – needs to be built in from the outset. Practices should also consider what is being sustained. Is it a change of attitude, a change in process or a change in outcomes?

In many instances, the improvements being introduced are not specific to a particular problem but can be more broadly applied, such as to another clinical problem or to another clinical setting. As with sustainability, consideration needs to be given as to how spread could occur early in the project, whether to other problems or even to other primary care practices.

Innovation
It has been postulated by Batalden and Davidoff (2007) that systems of care are perfectly designed to get the results they achieve. In other words, if effective changes are to be introduced and care is to improve, primary care systems need to be redesigned to enable this to happen. Teams need to think differently if they are to find creative solutions to existing problems and improve the care they deliver.

One such example is the provision of timely access to care, allowing individuals to be seen when the need arises, on their day of choice (consistent with patient-centred care) (Murray et al. 2003). Timely access allows problems to be detected earlier, often preventing the development of more severe symptoms and reducing the use of health facilities such as hospitals.

This kind of redesign aims to reduce or redistribute the demand for office visits, while increasing the number of visit slots that are available by using new approaches such as shared medical appointments, morning huddles, telephone visits and communication by e-mail. If successful, these changes free up time for planned and preventive visits and proactive follow-up of individuals with chronic conditions. These changes can also lead to a more efficient use of the resources available in primary care and can foster the development of well-functioning teams.

Redesigning services requires a practice culture that supports innovation and improvement, where all team members are willing to think “differently” about the seemingly intractable problems they commonly encounter and are constantly looking for opportunities for change; where ideas for improvements are listened to, discussed and eventually tested; and where improvements are introduced rapidly and on a small scale before their broader implementation.

Strategies for Primary Care Transformation
If primary care practices are to move toward the approach outlined above, they will require external support and assistance. While these can be provided by a province or territory, or a region or community, they need to be based on two central tenets. The first is acknowledgment of the essential role that primary care plays as part of a high-performing healthcare system and a willingness to strengthen this role. The second is a commitment to using proven improvement approaches and methods to assist practices in redesigning the
way they function, so that they can incorpo-
rate the new concepts and approaches outlined
in this paper. Four forms of direct support are
required to enable practice-level transforma-
tion: strategies for increasing the skills of staff,
access to tools and resources, quality improve-
ment coaches and an effective spread strategy.

**Strategies for Increasing the Skills of Staff
Working in Primary Care**

Many family physicians and other primary
care providers remain unfamiliar with these
concepts and how to incorporate them in their
practice. Mastering this knowledge and skill
requires new approaches beyond traditional
continuing education models.

For providers in practice, one effec-
tive approach has been the use of IHI’s
Breakthrough Series (Learning Collaborative)
Model (IHI 2003). The core features of the
model – rapid tests of change, measuring and
reporting of performance on a regular basis,
and forming networks and learning from each
other’s experience – build on the principles of
adult learning and can be adapted in different
ways that make them more accessible and cost-
efficient. One example of this is a virtual learn-
ing community, where most of the learning
takes place through webinars, team conference
calls and access to an interactive website, with
fewer face-to-face meetings of the teams.

A key to the long-term sustainability of
a transformed model of care, however, is the
training and preparation of future primary
care providers. The new approaches to care
and the improvement methods to assist with
their introduction need to be integrated into
the curricula of learners, ideally with a practi-
cal rather than just a theoretical focus, and
featured in undergraduate as well as postgrad-
uate training. This would provide an oppor-
tunity for the exchange of resources between
different training programs for health profes-
sionals as they would develop a shared curric-
ulum that draws upon collective resources,
many of which already exist, rather than each
program designing something unique.

**Access to Tools and Resources**

Practices benefit from access to practical
resources and tools to assist with the transfor-
mation, including change packages (compila-
tions of ideas for improvement) and simple
improvement tools that can be easily intro-
duced or adapted in a variety of settings, and
examples of successful experiences in intro-
ducing change. Many of these resources can
be provided through an interactive website or
clearing house. Developing networks of provid-
ers who can learn with and from each other is
an integral part of effective transformation.

**Quality Improvement Coaches**

It is usually not enough just to provide
resources and tools for practices. Often, the
key to successful change is redesigning the
practice setting to enable the optimal use of
these new resources and to improve processes
to achieve more efficient and effective care.
For example, team meetings may be identified
as being potentially beneficial, but a practice
team may need to find ways to protect time so
that team members can attend these meetings.

A consistent element in the success-
ful introduction of improvement methods
and adopting evidence-based guidelines
(Baskerville et al. 2012) has been the presence
of quality improvement coaches. Coaches can
assist practices to identify where changes may
be beneficial and to find ways to introduce and support new approaches. A coach's role should be time limited, gradually withdrawing as the team members become more confident in the changes they have made, while continuing to support them less intensively during this transition period (Knox et al. 2011). This method helps to increase both the skills of the practice team (building capability) and the range of services a team can offer (building capacity).

An Effective Spread Strategy

Although innovation is likely to begin with only a small number of physicians and practices, much can be learned from their experience and successes. A key to system transformation is a spread strategy that facilitates the communication of successful improvements between practices so that they can be adopted by other providers and adapted to other problems.

Ways to achieve this include building networks of providers so that they have a forum at a local or regional level to exchange information and support each other; using electronic media to share successful projects with colleagues who may be interested; identifying champions who have introduced improvements in their practice and are willing to meet with colleagues in the same region or province to share their stories and encourage others to move in a similar direction; and supporting tests of change aimed at resolving other problems.

System-Level Enablers of Primary Care Transformation

Widespread transformation at the practice level as described above is only possible in the context of supportive policies and structures at the system level:

- **The creation and ongoing support of primary care organizations or governance mechanisms at the local, regional and provincial/territorial levels** that give primary care providers a collective voice and enable them to assume collective responsibility for addressing population health needs, to engage effectively with other healthcare sectors and, at the local or regional level, to promote, coordinate and support quality improvement activities and share resources.
- **Well-defined, measurable goals** for the system, to provide common targets and more consistent delivery of care.
- **Patient enrolment with primary care providers and organizations**; this provides a foundation for a proactive, population-based approach to preventive care and chronic disease management and for systematic practice-level performance measurement and quality improvement.
- **A system of primary care performance measurement** that meets the information needs of the public, governments and ministries of health, regional health authorities, local communities and primary care practices and organizations for the purposes of public reporting, accountability, planning and quality improvement.
- **Policy and funding support for interprofessional teams**, which are integral to effective population-focused care.
- **Funding and provider payment arrangements that are aligned with quality goals**, including blended payment arrangements for physicians and the judicious use of targeted incentives.
- **Health IT that effectively supports patients and providers** through decision support tools for clinicians and patients, support for patient self-management, performance measurement and reporting capacity and interconnectivity for information exchange across healthcare settings.
- **Mechanisms to support coordination and...**
integration, which could include mandatory requirements for the content and timeliness of communication at care transition points and funding mechanisms that span care sectors such as bundled payments for episodes of care or multi-sector capitation covering the general population or specific subpopulations (e.g., people with complex chronic illness); given the uncertainty about feasibility and impact, payment innovations need to be tested on a small scale before system-wide adoption.

- **Systematic evaluation of primary care services and policy innovation** to allow shortcomings to be identified and addressed and successes to be reinforced and spread.

- **Adequate funding of primary care research and research training** to supply evidence to inform policy, management and practice.

**Conclusion**

Improving the health of populations and enhancing the experience of receiving care in a sustainable way requires changes in the way that primary care is organized and delivered. The six characteristics of high-performing primary care organizations, which are outlined in this paper, will enable providers and practices to meet the needs of patients, families and the communities in which they live. Achieving this on a broad scale will require a supportive health system environment and the use of proven quality improvement methods and supports such as external coaches as well as policies and structures at a system-wide level to reinforce and make possible the changes required.

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Let’s talk.
Healthcare Papers

COMMENTARY
ABSTRACT

Understanding the issues in advancing quality in Canadian primary healthcare requires some comprehension of systems theory as it applies to healthcare, as well as an understanding of the context of Canadian primary healthcare, particularly the roles of family physicians. With that background, one is then prepared to appreciate the current challenge in advancing the quality agenda, where provider learning of the content and skills of quality improvement and leading change, models of community or regional governance, and infrastructure such as information technology and its necessary supports for interoperability with other healthcare systems, are all primitive. For primary care providers, driven in large part by their desire to improve the health of the individuals and populations they serve, “Framework for Advancing Improvement in Primary Care” is a welcome guide for direction in how to begin their quality journey. The framework provides the map with the destination (the Institute for Healthcare Improvement’s Triple Aim) and roads to get there (six characteristics of high-performing primary healthcare systems). Finally, our ability to improve the system builds from partnerships with our practice citizens – we need to move beyond the patient care construct.
Understanding the issues in advancing quality in Canadian primary healthcare requires some comprehension of systems theory as it applies to healthcare, as well as an understanding of the context of Canadian primary healthcare, particularly the roles of family physicians. With that background, one is then prepared to appreciate the current challenge in advancing the quality agenda, where provider learning of the content and skills of quality improvement (QI) and leading change, models of community or regional governance, and infrastructure (e.g., information technology and its necessary supports for interoperability with other health entities) are all primitive. Such is the situation in a sector that remains frustrating in its seeming isolation from other elements of healthcare, both horizontally and vertically, particularly in large urban settings where much of the nation’s population is concentrated. For primary care providers, driven in large part by their desire to improve the health of the individuals and populations they serve, “Framework for Advancing Improvement in Primary Care” (Kates et al. 2012) is a welcome guide for direction on how to begin their quality journey.

Learning about systems theory as it applies to healthcare provides us with a pedagogic understanding of health systems and reinforces what previously had been clinicians’ intuition from years of experience. Health systems are complex adaptive systems (Plsek and Greenhalgh 2001). As such, they share certain characteristics such as unpredictability, being made up of multiple subsystems whose boundaries are not discrete and participants within the system who often act from their own internalized rules that may seem illogical to others (and often generate tension and paradox as natural phenomena). As a result, the system evolves in a non-linear fashion, and perturbations of any scope can result in little to major changes and, sometimes, unintended consequences. In that context, attempts at system improvement should entail multiple approaches, usually based on small-scale change with incremental implementation. Learning occurs primarily from observation and the use of tools often from social science methodologies, rather than the traditional scientific method more familiar to most clinicians. The “system” of primary healthcare in Canada certainly reflects this theoretical construct of complex adaptive systems.

While primary healthcare incorporates many roles, including clinical (e.g., physician, nurse, nurse practitioner, pharmacist etc.) and non-clinical ones (e.g., a youth worker at a local youth drop-in centre), since the late 1960s Canada has built primary healthcare mainly through the evolution of the specialty of family medicine and the deployment of highly trained family physicians. Family physicians possess distinctive competencies by being based in the community and offering services that are continuous over time and across locations, by being comprehensive in scope within holistic and ecological paradigms and by coordinating and assisting in system navigation for those they serve (McWhinney 1997). A further characteristic of family physicians, reflecting the matching of their role to the complexity of healthcare, is that they are adaptable (Rosser 2006). Whether the needs of their clientele relate to screening and health promotion, facilitating life transitions, assessing and managing undifferentiated illness behaviour that may or may not lead to a diagnosis, acute and chronic disease management or end-of-life care and bereavement support, family physicians adapt to their patients’ needs and to the resources that come and go within the system in support of their meeting those needs. Starfield, in not only advancing the construct that excellent healthcare systems are built through a foundation of primary
healthcare, argues that the discipline of family medicine should lead and shape healthcare reform in the United States (Starfield 2009). Many initiatives across Canada in recent years have advanced other primary providers such as nurse practitioners, often filling niche areas or complementary roles. The College of Family Physicians of Canada reported in 2008 that 86% of Canadians had a family doctor (College of Family Physicians of Canada 2008), and it set a target to grow this to 100%. Certainly systems such as that in the United Kingdom, where all citizens are enrolled to a general practice, with their health information electronically encoded, are recognized with superior performance results (Commonwealth Fund 2011). Given the ever-increasing complexity involved in providing primary healthcare, a variety of initiatives have led to the development of teams and networks across Canada, including family health teams in Ontario, primary care networks in Alberta, family medicine groups in Quebec and chronic disease management programs and primary care divisions in British Columbia (College of Family Physicians of Canada 2011). For the most part, these teams are built from an initial foundation of individual patients linking with individual family doctors. In the face of this tightly interdependent relationship with their patients, their scope of clinical competency and the breadth of service provision, their powerful roles within their practice environments, and their current level of penetration in the primary healthcare marketplace, family physicians are well positioned to lead improvement within primary healthcare. Until now, however, like other medical professionals, they have not been trained in the skills of quality improvement and how to become system managers or lead change. Frameworks for improving quality in healthcare in Canada must recognize and address this central stakeholder role of family medicine and the need for professional development for these specific competencies.

Focusing on the role of the family physician is thus necessary, however not sufficient. System capability must be beyond the sum of the competencies of its stakeholder providers. While Canada can be proud of its growth in highly trained primary healthcare professionals of all disciplines, their ability to succeed with improvement in elements such as system performance measures requires the building of primary care infrastructures that facilitate and support system integration. While integration is often greater in smaller and rural centres where providers are more ingrained with their hospitals, other healthcare institutions and communities, integration is often perversely lacking in large urban centres despite the resource base, as providers exist in greater anonymity.

The utilization of the skills of quality improvement at the practice level, for example with the Model of Improvement (Langley et al. 2009), does not require information system implementation. However, documenting system measures populated with data from the provider-patient interface does. While “Framework for Advancing Improvement in Primary Care” effectively outlines the issue in its third section detailing system-level enablers, information system implementation should be highlighted as a required first step before quality improvement of any signifi-
The Challenge of Advancing Quality in Canadian Primary Healthcare

cance can be expected to occur. Most of the initiatives described as tools and systems for improvement either have an evidence base that is focused at the project level or have occurred within the context of primary care systems that have a level of integration and implementation of information technology far beyond that which is currently present in Canada. Focusing on the introduction of QI initiatives with the expectation of scaling them across the system, prior to the implementation of those system enablers, will lead to a rebellion from primary care practitioners and a level of tension within this complex adaptive system that could have hugely unintended consequences!

With the aforementioned as context, I find Kates et al.’s quality improvement framework to be an effective contextual map to facilitate quality improvement in primary care. It sets direction, built from the Triple Aim framework, and stimulates systems thinking in an ecological context, with individuals centred within their close and important personal relationships and social supports and within communities. Finally, it places specific roads on the map, the six characteristics of high-performing primary healthcare models. My final comments are to emphasize some “nuances” with respect to the framework.

Appropriately, the framework begins by centring on the individual. I offer again the importance of considering that individual in the context of having a major stakeholder relationship with a primary care provider, overwhelmingly in Canada that being a family physician. These practitioners themselves have a leadership role within their teams and responsibility to effect change at the practice level.

Within the health care system we tend to think of patients. We must caution ourselves to think beyond such dependency-laden terminology such as care of patients, to relationships with our practice citizens. The potential for true partnerships between equals can then evolve. Perhaps then we would consider more naturally factors as such as self-management and respect for autonomous direction and empowered decisions around citizens’ health choices. Now we move into a world of our responsibility to our clientele, to ensure they have the health literacy necessary to support their decisions, to engage them as partners in planning services and to consider such factors as making quality of service provision transparent to those we serve including, at least in part, their elected officials through public reporting. To that end, I find that the Triple Aim also speaks from the provider context as it emphasizes patient care as opposed to health. Focusing on health would broaden our mandate to other professional roles such as advocate, one of the expected roles of the effective family physician (College of Family Physicians of Canada 2009). In that way, our thinking certainly is in a population health context; however, now the focus may include our communities, not just those members who are our patients.

I note that the accompanying graphic to the quality improvement framework (Figure 1 in the lead essay) paraphrases the second Triple Aim desired outcome to be not only improved patient experience but “improved patient and care team experience” [emphasis added]. I welcome this addition. However effective a proposed quality improvement initiative may be perceived, its implementation and sustainability will be greatly compromised if it expects everyone to achieve improvement by working harder!

Finally, we must address the science of quality improvement when we discuss measuring to improve, well described by Donald Berwick (2008). The nature of quality improvement within complex health systems means we must initiate many small incremen-
tal changes, measured repeatedly using a variety of methodologies, that cumulatively power our learning about our systems. The science of Deming and his Theory of Profound Knowledge (as cited in Berwick 2008) guide us to the questions we must ask as we recognize the major components of system change:

- Systems thinking – What is the whole system, and how do the different parts interact with each other?
- Variation – What does the variation in measured results tell us about the system?
- Knowledge – What are the predictions about the system's performance, and what theories inform these predictions?
- Psychology and human behaviour – How do the people in the system react to change? What are the important interactions? What motivates them?

The methodologies that we thus use to learn about the system and evaluate its performance are many and varied – there is no one size that fits all. This can be particularly confusing for healthcare professionals and policy makers!

To sum up, “Framework for Advancing Improvement in Primary Care” is an excellent contextual guide for those beginning their improvement journey. Recognition is required, however, that primary healthcare is complex and that our current Canadian system is faced with significant challenges. There are many excellently trained primary care providers, and in our system the emphasis has been on the centrality of family physicians. Their cumulative performance at the systemic level is constrained by a lack of primary care infrastructure, highlighted in the lead essay as necessary enablers. These need to be emphasized as required before significant systemic improvement in primary healthcare can be expected, regardless of the initiative. Finally, our ability to advance quality hinges on our fundamental relationships with our practice citizens – we need to move beyond patient care constructs to recognizing the opportunity for true partnerships with equals, and together improving quality.

References


Frameworks and Primary Healthcare Policy

COMMENTARY

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ABSTRACT

Healthcare reform in Canada needs to start with primary care reform, putting patients and their caregivers at the centre of the health system. Although the directions are well accepted, primary care reform requires changes to organizational structures (moving toward multidisciplinary practice) and to physician remuneration to be effective. Without action on these system-level enablers, little real action will be able to occur in repositioning the healthcare system.

Frameworks are useful teaching and rhetorical devices; they help to organize your thoughts and convey, often visually, an overall summary of or direction for the issue at hand. To some extent they are propaganda tools: their design emphasizes the points the designer wants to emphasize, highlight or illustrate. They help to create a meme about how a particular policy or issue ought to be considered.

Kates et al.’s (2012) framework, summarized and represented visually in their Figure 1, is presumably designed to provide an impetus to primary care improvement in Canada, highlighting six key characteristics of a transformed primary care system, and the Triple Aim of where we want to be. By their very nature, visual frameworks must simplify a complex reality; so what is instructive is to assess what has been simplified out.

We all have our favourite models and frameworks: in my talks on system transformation, I describe the system as being
(or, more accurately, needing to be) a system of concentric circles, with the patient at the centre (and needing to be supported), the patient’s caregivers forming the next circle (supporting and themselves needing support), the primary care team next and so on out to global influences (Duckett 2012).

The political point I’m trying to make in my presentations (and which influences my visual portrayal) is the need to start differently from the hospital- and specialist-oriented health system that I found when I arrived in Alberta (and unfortunately that remained when I left).

Possibly the most famous framework or visual model is Wagner et al.’s (1999) chronic care model (see http://www.improving-chroniccare.org/index.php?p=The_Chronic_Care_Model&s=2), described as the lingua franca of chronic disease management (McColl and Dorland 2007). The focus of Wagner’s chronic care model is a “productive interaction” between an “informed, activated patient” and a “prepared, proactive practice team”; both sides of this interaction require support. In Wagner’s model, support comes both from the community (in terms of resources, policies and self-management support) and from the health system, involving improvements to the organization of healthcare, delivery system design, decision support and clinical information systems. Wagner’s model is interesting and unusual in that it provides equal billing to the consumer and provider sides of the chronic care interaction, really highlighting the importance of patient engagement. The model also picks up on the many support systems that are needed to ensure the productive interaction actually works.

**The Missing Pieces**

**What Are Teams?**

The need to invest in, and change the shape of, primary care is well recognized. A number of provinces have started that process, but progress is uneven (Hutchison et al. 2011). Hutchison et al. conclude their review of primary care transformation in Canada with faith that laggard provinces “will likely follow the leaders, each in its own way and in its own time” (2011: 282). They trace the stimulus for the transformation to actions taken at the national level in the early 2000s. The slow progress of reform in some provinces (which were exposed to the same stimuli) suggests that the existing mechanisms to facilitate policy transfer are not working and that more needs to be done in this area. This volume might facilitate that needed policy transfer; but to do that, the framework must highlight what needs our attention so that it helps to map a complete plan of action.

The Canadian healthcare system as we see it today is the clear descendent of the health system of 60 years ago, familiar to Tommy Douglas and his colleagues when they developed the Saskatchewan antecedents of medicare. But the health issues then are not the same as they are today; nor are the treatments. Remuneration levels for physicians have improved (Duffin 2011), but the primary care structures of relatively small, autonomous, family physician practices, operated on a private basis with fee-for-service reimbursement, have been a constant. Not that physicians necessarily want to maintain fee-for-service as the principal remuneration model: alternative models of reimbursement are growing both in terms of number of physicians and proportion of physician remuneration (Wranik and Durier-Copp 2009).

Tommy Douglas saw the introduction of medicare and the removal of financial barriers to access as being the first of a two-phase reform process. The second phase was to include change to the delivery system, including primary care restructure through an emphasis on group practice (Douglas 1979).
Group practice isn’t the only needed change in primary care. Financial incentives on providers and organizations also have to be aligned with the new models. Kates et al. recognize this in their paper when they discuss in their final section the “system-level enablers of primary care transformation.” In my view, these system-level enablers are the sine qua non of primary healthcare reform: without the right (financial) incentives on providers, one cannot expect all but the most altruistic practices to change; without support in that transition (well described in the Kates et al. paper), practices will not know how to effect change.

There is a vast agenda of changes that are required, and the necessary change won’t come easily. Traditionally, primary medical care was delivered in physician-owned solo practices. Over the past few decades, the average practice size in Canada has increased; but in 2011, more than one fifth of family physicians (22.3%) still practised in a solo practice (National Physician Survey 2010). At least in the United States, smaller practices are less likely to support elements of a new model of care associated with best practice chronic disease management (Rittenhouse et al. 2011). Care of people with chronic illnesses requires access to a range of professions; but in 2011, less than one quarter of Canadian family physicians worked in multidisciplinary practice settings (21.4%).

Team-based care is portrayed in the Kates et al. framework as one of the six defining characteristics of the transformed model. But what do we mean by that? The relevant paragraphs of the paper seem to have the agent deleted: Who is to apportion responsibilities? Is the appropriate team analogy the baseball or the basketball team?

For most of us (physicians), the model of teamwork is baseball, where a collection of well-paid superstars are judged by personal performance with occasional situational collaboration, like a double play. We accept the football model of teamwork, where one individual directs an unquestioning cadre of supporters with special skills toward the goal line, only when we are the quarterbacks heading a team of non-peers. But where in medicine do we follow a basketball model of teamwork, in which a collection of peers appropriately takes responsibility as dictated by the situation, then relinquishes it in a similar manner? That sort of teamwork is critical to the effectiveness of many organizations, yet it does not fit the psychological makeup of most physicians. (Mayer 1999: 16)

Follow the Money
But what sort of team we are talking about pales into insignificance when we come to considering remuneration. When medicare was first designed, it incorporated the then-dominant funding method for physicians – fee-for-service practice – and that has remained. But fee-for-service is particularly inappropriate in primary care dominated by chronic illnesses. By its very nature, fee-for-service rewards episodic care rather than a long-term-care relationship with a person with chronic illness. Fee-for-service remuneration can also act as a disincentive to the use of other health professionals such as nurse practitioners (DiCenso et al. 2011).

Who gets what is the stuff of politics, and so remuneration policy could be expected to be highly contentious. Physicians and physician organizations value “professional control” almost above everything else (Blishen 1969). The founding bargain of medicare had as its objective “to find a way of combining publicly supported universal coverage with the true essentials of professional freedom” (Taylor 1978: 323). In reality, this meant that
“organized medicine was able to improve the economic position of its members even while it preserved the contractual system of remuneration and private practice, protected the role of physicians at the centre of the healthcare system, and prevented major changes to primary healthcare” (Marchildon and Schrijvers 2011: 222).

Not only did fee-for-service payment continue as the dominant payment mode, “professional freedom” was further operationalized as a requirement that payment levels and relativities be negotiated with the medical profession. The *Canada Health Act* enshrines this requirement for negotiations but goes further to enhance the power of professional organizations by requiring provinces to establish arbitration processes “for the settlement of disputes relating to compensation through, at the option of the appropriate provincial organizations … conciliation or binding arbitration by a panel that is equally representative of the provincial organizations and the province and that has an independent chairman; and that a decision of (such) a panel … may not be altered except by an Act of the legislature of the province” (Department of Justice, Canada 1985: Section 12 [2] [b] and [c]). Consistent with the professional-freedom basis of the profession-state accommodation, intra-professional distribution of fee increases was generally ceded to the professional associations. All this has conspired to make the shift from fee-for-service glacially slow. Any carve out from the global physician services budget to establish new alternative payment plans needs to be endorsed by the provincial medical association. Although shifting the arena for intra-professional fee setting to one managed by the profession itself has some political benefits, it also has downsides. The interests of the profession and government/health system/public are not necessarily coincident. If the health system is to be reoriented toward primary care, that has the corollary of a reorientation away from specialist care. The cohesive interest of a minority group of stakeholders can be easily harnessed (Easton 1979) and can be used to block proposals for redistribution (e.g., ophthalmologists in British Columbia successfully blocked fee reductions for cataract operations [Katz et al. 1997]).

Enlightened leadership in physician associations may accept the need for system reorientation, but such leadership cannot be guaranteed in every province, every year. Even if it could, the leadership might not be able to ensure that the broad membership of the physician association would endorse a negotiated reform proposal. On the other side of the negotiation table, the desire to conclude an agreement might lead to a focus on the big issue of the size of the increase in remuneration to be awarded, sidelining discussions on structural change to remuneration to facilitate system reform. The structure of remuneration is one of the critical policy levers that drive reform of the healthcare system. The Canadian accommodation, where use of this lever is attenuated by passing through physician organization processes, potentially weakens and slows the necessary system reorientation.

**A Revised Framework?**

Kates et al.’s framework identifies the issues I have raised in their list of system-level...
enablers. But what I’ve suggested here is that the Kates et al. framework needs to highlight appropriately the salient issues they themselves have identified. Figure 1 in particular needs to be adapted to highlight the system-level enablers, the organization structure changes and remuneration strategies that will be required to facilitate the needed transformation of primary healthcare. By relegating these issues to a list at the end of their paper and not including them in their visual framework, they implicitly de-emphasize their importance.

Primary care reform requires political (and system) leadership to ensure the system-level enablers are in place to support the local-level changes described in more detail in the paper by Kates et al. Without recognition of, and action on, these political system enablers, primary healthcare reform will occur only among the altruistic, dedicated zealots rather than having a system-wide impact.

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Of Honey and Health Policy: The Limits of Sweet, Sticky Substances in Reforming Primary Care

COMMENTARY

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ABSTRACT

It is a well-known axiom that one attracts more flies with honey than vinegar. Nowhere has this approach been taken more to heart than in the past decade of primary care policy in Canada. Governments, physician and nursing organizations and regional health authorities have invested in a lot of “honey” to draw healthcare providers onto a path from single-physician offices to team-based care with flexible hours and a population-based approach. In the lead essay for this edition of Healthcare Papers, Kates and colleagues have outlined a framework that embraces this paradigm. Their articulation of a framework is a place to start, but it can only be a start. To make that framework come alive, a wider variety of policy tools will be needed than have been used thus far, and by a wider variety of actors. Within the healthcare workforce itself, leadership, vision and the courage to hold ourselves to account for changes to primary care are needed.
more flexible hours and on-call coverage; and from individual care to a population-based approach to wellness, illness prevention and the management of chronic disease.

In the lead essay for this edition of Healthcare Papers, Kates and colleagues (2012) have outlined a framework that adopts this approach. They make a series of suggestions for getting from where we currently are to where we all agree we need to be. Yet their proposed implementation approach has been tried on a small scale in Ontario with mixed results, at least where there has been any published evaluation (Glazier et al. 2012; Hurley et al. 2011; Kiran et al. 2012; Office of the Auditor General of Ontario 2011; Rosser et al. 2010; Tu et al. 2009). In my view, this is not because the framework or vision is lacking, but because the tools it proposes, and that we have been using, are insufficient for the job.

In order for a framework for change to be meaningful, it must infiltrate day-to-day work in the system. The ideas for change need to be sticky; not like Velcro (quick to stick and then unstick when the next “new” idea comes along) but actually like honey – flowing between the cracks in the system, making a larger picture of disparate pieces and rendering movement away from core principles at least mildly more difficult. Honey, then, is not just a sweet substance to attract providers to new ways of doing things; it is also a “soft” approach to making policy stick.

Is honey enough? Can policy makers and patients continue to hope that incentives, coaching and exhortation will move primary care providers and systems? The implementation question simply cannot be ducked: our framework for change must include effective tools for getting the job done, with built-in accountability. Furthermore, a broad vision, as articulated by Kates et al., needs to be championed not only in an instrumental but also a symbolic way, building a case among health-care providers for why we need to aspire to something different from what we think we were trained to do. Without a more inclusive set of tools – a little honey, a little vinegar, a little duct tape – primary care in Canada will be sentenced to incremental change in lucky little pockets of the country.

The Vision for Primary Care

The strength of the model proposed by Kates and colleagues lies in a clear articulation of an ideal end state in which the Triple Aim of better health, better care and better value are the ongoing focus of continuously improving primary care practices that are plugged into population needs and community resources. Most of these ideas are not new to primary care in general, or to family medicine in particular. Their foundation lies in part in the Four Principles of Family Medicine (Table 1), long articulated by the College of Family Physicians of Canada (1985), and in the Patient-Centred Clinical Method (Figure 1), developed at the University of Western Ontario and now a foundational tool in the education of family doctors (Stewart et al. 2003). The Kates et al. model stands on the shoulders of these giants. The former articulates the community-oriented, population-focused and relationship-based nature of family medicine. The latter, which caused a revolution in family medicine education, articulates the role that individual experiences, familial and community factors and broader social contexts play in achieving optimal health.

The resemblance between Kates et al.’s model and these two foundational theories of primary care is to be celebrated. A new framework does not arise out of thin air; it builds on the richness of the frameworks that preceded it, and takes them one step further. So it is with this model – it all sounds very familiar until we reach the last few items on the list. Kates et al.’s population focus, patient
engagement and partnerships with health and community services are all covered in the four principles of family medicine; the “new” focus recognizes the critical importance of team-based care and performance measurement/quality improvement. Team-based care is increasingly the norm in primary care across the country, but the notion that we as healthcare providers should be constantly measuring our successes and failures and then adjusting our approach still feels foreign, even to practitioners who have entered the healthcare system in the past decade.

Similarly, while the desired outcomes of better health and better care are embedded in the patient-centred model, the notion that better value matters is a new and welcome addition to our way of thinking about the goals of primary care. It is also far from widely accepted: the primacy of the provider-patient relationship has often been constructed as being at odds with any system-level goals – especially when those goals might include saying no to oneself or to one’s patients for the good of the collective. The sacred individual bond between provider and patient, although a strength of our system, can also act as an impediment to needed reform.

It seems, therefore, that the major contribution of the framework by Kates et al. is the way in which it looks beyond the physician-patient dyad to think about how other team members, the healthcare system and the broader population need to be a focus of our attention. Of course, once we look beyond the physician, the changes that ensue must inevitably involve substantial changes to physician behaviour. The challenge we face is that success along those axes is much harder to measure, and the accountability for it is, by necessity, shared accountability.

Shared accountability is the kiss of death in too many areas of public policy, and the Kates et al. framework stops short of describing how it might be attained – perhaps because of the highly political nature of such recom-

<table>
<thead>
<tr>
<th>Table 1. The Four Principles of Family Medicine</th>
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<tbody>
<tr>
<td>1. The family physician is a resource to a defined practice population.</td>
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<tr>
<td>2. The physician-patient relationship is central to the role of the family physician.</td>
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<tr>
<td>3. Family medicine is a community-based discipline.</td>
</tr>
<tr>
<td>4. The family physician is a skilled clinician.</td>
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Source: College of Family Physicians of Canada (1985).

![Figure 1. The Patient-Centred Clinical Method](image_url)
mendations, but perhaps also because of the absence of good tools to enforce true accountability in our current primary care systems. In the remainder of this essay, I explore the central issue of how to think about implementation tools for a framework such as this one.

**Policy Instruments and Options**

Public policy tools always exist to try to get people to do things they would not otherwise do. In their seminal work on policy tools in 1990, Schneider and Ingram identified five broad categories of policy tools: authority-based tools, incentives, capacity-building, symbolic and hortatory, and learning. They point out that each of these approaches relies upon different assumptions about what makes people act and change. In my view, we can learn from this framework to help build on the Kates et al. model.

In Table 2, I map the proposed transformation strategies identified by Kates and colleagues against Schneider and Ingram’s categories to illustrate the point I am about to make. Readers of Table 2 might wish to move a few items around, but the essential point is clear: the strategies being used in Ontario and across Canada to achieve primary care reform are almost exclusively in the categories of incentives, capacity-building and learning. The strongest focus is on incentives, an approach that assumes that people and institutions will respond to (mostly) financial carrots; and on capacity-building, which assumes that people want to change their behaviour but don’t know how to do so. Learning approaches are used when we don’t know how to achieve our goals and must therefore invent and then measure as we go.

However, the two other categories of policy tools – authority, where government or other institutions simply require, prohibit or mandate activities (the most common type of tool used in most other areas of public policy), and symbolic/hortatory tools, which involve building a values-based case for change – are missing from this framework and, indeed, I would argue, from primary care reform in Canada. This is not an accident. Primary care plays out in a set of non-systems: single-provider general practitioners’ offices sit alongside large multidisciplinary community health centres, nurse-led clinics and walk-in clinics. Few of these talk meaningfully to each other or to the hospitals, pharmacies or social service delivery organizations in their communities. Most view government as a payer rather than a partner in co-producing health. No

<table>
<thead>
<tr>
<th>Category of Policy Tool*</th>
<th>Practice-Level Tools Advocated by Kates et al.</th>
<th>System-Level Tools Advocated by Kates et al.</th>
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<tbody>
<tr>
<td>Authority</td>
<td>–</td>
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<tr>
<td>Incentives</td>
<td>Access to resources</td>
<td>• Funding incentives</td>
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<td></td>
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<td>• Support for inter-professional teams</td>
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<tr>
<td>Capacity-building</td>
<td>• Support from coaches</td>
<td>• System of local primary care organizations</td>
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<td></td>
<td>• Spread and sustainability strategies</td>
<td>• Patient enrolment</td>
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<td></td>
<td></td>
<td>• Support for coordination and integration</td>
</tr>
<tr>
<td>Symbolic and hortatory</td>
<td>–</td>
<td>Clear goals</td>
</tr>
<tr>
<td>Learning</td>
<td>–</td>
<td>• Performance measurement</td>
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<tr>
<td></td>
<td></td>
<td>• Evaluation of innovation</td>
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<td></td>
<td></td>
<td>• Research funding</td>
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*From Schneider and Ingram (1990).
one is clearly in charge. Governments have hesitated to use authority-based tools with independent private practitioners (most notably physicians). Regulatory and professional colleges have primarily concerned themselves with establishing competency requirements for licensing and responding to patient complaints of egregious behaviour. So far, our collective professional bodies have not laid out any professional obligation to engage in achieving the kind of broader vision laid out by Kates et al. And we have yet to see a concerted effort by governments, physician organizations or other institutions to control the symbolic agenda in a meaningful way.

This might be acceptable if clear evidence were on the table to show that the tools embraced by Kates et al. work. But, at best, the early evidence has been mixed: more citizens have been rostered to family physicians, but it is debatable whether any significant improvements in access or quality of care have resulted (Glazier et al. 2012; Hurley et al. 2011; Kiran et al. 2012; Office of the Auditor General of Ontario 2011). As for capacity-building tools such as quality improvement coaches, if these are as successful as academic detailing programs, they are likely to be modestly (although not enormously) successful – for those who choose to participate, one practice at a time (O’Brien et al. 2007).

**Integrating Authority and Symbolic Tools into the Repertoire**

I am not suggesting that incentives and capacity-building tools should not be used in moving the framework by Kates et al. from the page to the community. But a framework that uses only these tools seems limited. For starters, surely some authority – some vinegar – could be useful here.

Governments have some ability to legislate and regulate some of the conditions necessary for true primary care renewal. They decide which health professions are self-regulating, deal with scopes of practice, decide which services will be publicly reimbursed and negotiate the rates of reimbursement. So far they have treaded lightly in the area of primary care other than to invest heavily in incentives; but more could be done. This is not to say that governments should suddenly start micro-regulating the activity of primary care practices. Were they to do so, they would inevitably get it wrong.

At the same time, surely we can think of some creative ways to use our own authority – that of the self-regulating healthcare professions – to assist primary care as it moves toward its goal. Regulatory and accrediting colleges as well as professional associations and unions have an enormous role to play in ensuring that their members meet the professional duty to stay up to date. Being current is not only about clinical knowledge; it should include updating one’s orientation and the administrative aspects of one’s professional work to reflect best practices for the patients and the communities we serve. This is an area in which one must tread extremely carefully and delicately. Professional regulatory bodies are not the places for activist agendas – but nor should they reflect professional norms two generations behind the times.

As for the symbolic and hortatory tools: this is perhaps the crux of the whole issue.
The Triple Aim of better health, better care and better value will never be achieved unless healthcare providers explicitly see it as a personal and collective goal. Honey is no match for long-entrenched professional values and cultures. We need to bind ourselves with something harder to the ideas and values that underpin this new approach. Physicians have for at least two generations worked in a model that is now at odds with the kind of change needed to advance healthcare. One could make an argument that change will only come with a generational change of physicians who are trained in the new model. Are we willing to wait?

If not, we will need to win the hearts and minds of the current healthcare workforce. This can't be done with incentives and coaching alone; we need to tell a story that resonates with the values and aspirations of our best selves. As healthcare providers, we need to own the vision of the future and see the barriers to achieving it as our problems to solve. Perhaps Kates et al.'s articulation of a framework is a place to start, but it can only be a start. In my view, that leadership and vision cannot be imposed externally. They have to come from within the healthcare workforce, gathering strength from government and public support.

Who will write the narrative for primary care for the decade to come? How can practitioners, patients and politicians come to a place where better health, better care and better value just “feel right”? Who will take ownership of this framework and carry it into the consciousness of those whose job it is to make it come true? The first to step forward in that task will face an uphill battle, but one well worth the fight.

Acknowledgements
I would like to thank Margaret McGregor, Nick Pimlott and Irfan Dhall for their valuable feedback on this essay.

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A Framework for Community-Oriented Primary Healthcare

ABSTRACT
To build on the very valuable contribution of Kates et al., this commentary takes a population health perspective and provides a complementary framework and means of accelerating transformative change in community-oriented primary healthcare (COPHC). The six basic requirements that make up this framework are (1) a geographical population focus, (2) patient and community engagement – a governance mechanism, (3) comprehensive COPHC services, (4) collaborative inter-professional teams and partnerships, (5) performance measurement and quality improvement and (6) innovation in financing. Transformative change in COPHC can be accelerated by the following: an increase funding for the primary prevention of chronic disease; the facilitation of inter-professional collaboration with resources and data; the development of indicators and databases for the above six basic requirements; and annual public reports by the Health Council of Canada based on these indicators to track progress in the transformation of COPHC, with the co-operation of the Canadian Institute for Health Information. The 6% annual uplift in the Canada Health Transfer is a potential source to fund these initiatives.
Kates et al. (2012) have written their paper largely from the perspective of improving the performance of medical practices, while recognizing that this will be aided by improvements in communities and the broader healthcare system. From this perspective, the paper is an excellent contribution. In this commentary, a population health perspective is emphasized, a complementary framework for community-oriented primary healthcare (COPHC) services is presented and suggestions for accelerating transformative change are made.

Framework for a COPHC Services Organization
Taking a community rather than clinical practice perspective requires expanding on Kates et al.’s framework. The best available evidence (Suter 2009) suggests the following six requirements:

1. A focus on a geographically defined population
2. Patient and community engagement – a governance mechanism
3. Comprehensive health services
4. Collaborative inter-professional teams and partnerships
5. Performance measurement and quality improvement
6. Innovation in financing

Focus on a Geographically Defined Population
COPHC organizations should serve a geographically defined population such as a municipality or large neighbourhood. Data collection, community profiles and reporting at this level include health status, health inequities and the social and economic determinants of health as well as healthcare system performance characteristics. They may also inventory health and community resources and services. Data collected in individual clinical practices in the community can augment these community-level data. This community focus facilitates the development of collaborative relationships between clinicians, public health professionals and local governments, agencies, businesses and non-governmental organizations (NGOs) to address both clinical care and population health needs.

Patient and Community Engagement: The Need for Governance
Patient-centred care, patient engagement and the “patient voice” are critically important to improving primary care. But so too is community engagement (Institute of Medicine. Committee on Integrating Primary Care and Public Health 2012). To facilitate community engagement, there is a need to develop governance mechanisms for community-oriented health services organizations that will allow communication between the community (patients and all other members of the community) and the service providers. In this way, gaps in service can be identified and the provider organizations can account for performance quality improvement and progress in improving the health of the population and reducing inequities.

Comprehensive Health Services
COPHC organizations provide comprehensive services that include both population health services and individual care as provided through clinical professionals. These services span population health assessments, health promotion, health protection, primary and clinical disease prevention and effective, integrated clinical care throughout the life course.

Collaborative Teams and Partnerships
These services are delivered by collaborative inter-professional teams, including public health professionals and community care and social agencies as well as family physi-
A Framework for Community-Oriented Primary Healthcare

cians, nurses, nurse practitioners, pharmacists, midwives, mental health workers, home and long-term care staff and others. This may be best achieved through facilitated networks (Christansen 2009) that are based on positive relationships between providers, patients and the community being served. At the community level, collaborative relationships are needed with local government, agencies, businesses and NGOs. To be successful, such networks and partnerships require facilitation and support including funding, information technology and data, leadership and vision, coordination (Chang 2012), shared values, positive trusting relationships, community engagement, evaluation and training (Institute of Medicine. Committee on Integrating Primary Care and Public Health 2012).

Performance Measurement and Quality Improvement

Kates et al. provide an excellent discussion of this topic. It will be essential to further develop fully functional, integrated electronic health information systems that incorporate electronic health records (EHRs, including clinical decision supports), community and best practice portals and linkages between population data systems (including financial information), public health, primary healthcare, acute care and quality improvement programs.

Innovation in Financing

The most critical innovation now needed is to increase investments in primary prevention so that we can reduce the burden of chronic disease, decrease healthcare costs and sustain publicly funded healthcare (Milstein 2011). Innovative financing to facilitate collaborative teams and partnerships is also needed for coordination (population health integrators), health information infrastructure (EHRs, databases, etc.) and team building. As discussed by Kates et al. innovative payment models for physicians are required to facilitate their collaboration with other providers and organizations.

Discussion

These six evidence-based requirements for COPHC place greater emphasis on a population health approach, in particular a geographically defined population, increased emphasis on (and investment in) primary prevention, collaboration between clinical and public health service providers and a governance mechanism for providing regular communication between providers and the community. The implementation of a framework incorporating the six basic requirements would also expand the capacity to address health inequities, which is now considered to be an important role for primary healthcare.

Kates et al. suggest that reducing health inequities can be achieved by collecting health and socio-economic data related to a practice population and then identifying and reaching out to those most in need. But a transformed COPHC system that emphasizes a population approach and fosters collaboration and integration with public health, community services and social agencies can do much more to reduce health inequities:

• In addition to data collected in clinical practices, in collaboration with epidemiolo-
gists and public health professionals, data on health and socio-economic inequities can be collated for the entire geographically defined population being served. This can be a source of information for regular reports and action plans for the healthcare community as well as municipal politicians, administrators and others.

- Through increased collaboration and partnerships between primary healthcare providers and community social agencies, the needs of individuals and families for income assistance, food, shelter and other social supports can be met. There have been successful collaborations in immunization, maternal and child health and the prevention and management of chronic disease (Institute of Medicine. Committee on Integrating Primary Care and Public Health 2012) particularly for marginalized populations.
- Resources within healthcare organizations and also municipalities, school districts and police and social agencies can be reallocated to better serve the requirements of population groups most in need.
- Healthcare providers and administrators can serve as advocates for addressing not only healthcare needs but also the broader social determinants of health, such as employment, income and food security, early child care and learning, education, housing and environmental sustainability.

**Accelerating Transformative Change**

The challenge is to implement the above six basic requirements and accelerate the transformation to COPHC. The Canadian healthcare system is under considerable financial stress, and there is widespread concern that it is becoming financially unsustainable. Economists have estimated that if healthcare budgets continue to increase at current rates, they may consume 80% of provincial government budgets by 2030 (Drummond 2010). In this scenario, the healthcare system becomes a major threat to the health of the population as it squeezes out expenditures on other important government functions such as education, income assistance, social housing, justice, early child care and learning, environmental sustainability and other determinants of health (Plecash 2011). These increasing healthcare costs are mostly driven by expenditures on drugs, technology and human resources used in the treatment of a large and growing burden of chronic diseases, most of which could be prevented by upstream investments in primary prevention (Canadian Institute for Health Information 2011). Demographic changes contribute as well but are both smaller and less controllable. Evidence from dynamic system modelling analyses shows that over the mid- to long term (up to 25 years), increased investment in primary prevention (public health) of chronic disease will lead to reduced healthcare costs and return sustainability to the system (Milstein 2011).

As Kates et al. note, “system-level enablers” including “systematic evaluation of primary care services” are critical to accelerating the pace of COPHC transformation. Discussions toward the 2014 Health Accord between the federal and provincial governments offer a practical way to make this happen. The federal government in 2011 agreed to the continuation of the Canada Health Transfer (CHT). Over the next five years, the funds from the CHT (approximately $30 billion annually – plus $14 billion in tax points – transferred to provinces for healthcare, providing about 30% of provincial healthcare programming) will increase at a rate of 6% per year. While governments will continue to manage competing priorities for new expenditures, the analysis above points to the need to increase investment in primary prevention and public health. As discussed, this will be most effectively achieved by better
collaboration and integration of primary care with public health and community-based care (home care, long-term care, mental health services). At present, expenditures on public health are estimated to be about 2–3% of health spending in most provinces; this should be at least doubled (which for most jurisdictions would be 5–6% or more) in the next five years in order to reduce the burden of chronic disease and “bend the curve” of rising health system expenditures.

The federal health minister has called upon the provincial and territorial health ministers to work co-operatively to achieve a more sustainable and accountable healthcare system and to “work on an approach to measuring and reporting performance across health systems using common metrics” (Aglukkaq 2011). This should include the development of COPHC indicators and data as a basis for annual reports by the Health Council of Canada on progress being made in integrating and improving the performance of COPHC organizations across Canada based on the six basic requirements, described above.

The priority action now is to set up a process with the federal government including the Canadian Institute for Health Information and the Health Council of Canada (as well as the major health-related NGOs), provincial governments and regional health authorities to agree on a set of indicators and databases to track performance and regularly report on progress in implementing these six basic requirements for COPHC transformation. The development and use of meaningful indicators — supported by data and CHT funding and regularly reported to the public by the Health Council — were successful in reducing surgical wait times following the 2004 Health Accord: “what gets measured gets done.” If done well and supported by funding from the CHT, this process of regular reporting based on reliable data will achieve the needed results in transforming COPHC, reduce the burden of chronic disease and bend the cost curve.

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Primary Healthcare Transformation: Moving from Common Sense to Common Practice

COMMENTARY

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ABSTRACT

There is no disputing that the key to any high-performing healthcare system is a high-performing primary healthcare system. As health systems around the globe grapple with aging, sicker populations, variable quality of care and unsustainable growth in health expenditures, the overhauling of primary healthcare cannot be put off any longer.

Patient centred. Community designed. Team delivered. These are the tenets behind Saskatchewan’s recently released framework for achieving a high-performing primary healthcare system. It has much in common with the primary healthcare framework offered by Kates and colleagues; and given its promising genesis, perhaps (finally) what has eluded many health systems so far can be achieved in the province that 50 years ago led the country in healthcare innovation.
Primary Healthcare Transformation

There is no disputing that the key to any high-performing primary healthcare system is a high-performing primary healthcare system. As health systems around the globe grapple with aging, sicker populations, variable quality of care and unsustainable growth in health expenditures, the overhauling of primary healthcare cannot be put off any longer.

Despite decades of reflection on what ails primary healthcare in Canada and recent reform efforts being implemented across the country to address these challenges, significant opportunity for improvement remains (Health Council of Canada 2011a, 2011b; Hutchison et al. 2011). The story is no different in Saskatchewan. In his 2009 report about Saskatchewan’s Patient First Review, Commissioner Tony Dagnone stated, “A fundamental redesign of primary health services delivery is urgently required in this province to serve patients better” (Government of Saskatchewan 2009). He recognized, like many others before him, that if primary healthcare is not working well, the whole system bears the consequences, from avoidable health breakdown to misuse of specialized services, fragmented care and inadequate follow-up.

It’s hard to find fault with the framework presented by Kates and his colleagues (2012). Indeed, its simplicity, fullness and practical expression speak to the lessons learned and experiences of those jurisdictions that have tried, with limited success so far, to overhaul primary healthcare. The Primary Health Care Framework released by Saskatchewan this past spring echoes and validates much of what is in the Kates et al. framework (Government of Saskatchewan 2012).

We don’t think that transforming and improving primary healthcare is or need be overly complex. But it will take unprecedented levels of curiosity, collaboration, capability, commitment and, most importantly, courage on the parts of all who work in and use primary healthcare. We appreciate this opportunity to share with readers our province’s nascent and unfolding efforts to improve primary healthcare for Saskatchewan residents.

Curiosity: Look to and Learn from the Positive Deviants

I remember, a number of years ago, André Picard, The Globe and Mail’s public health reporter, telling a group of Saskatchewan health system leaders: “Yeah, you’re the birthplace of medicare. Get over it.” For far too long, we believed we had one of the best healthcare systems in the world. But when this province’s Health Quality Council began to release report after report that showed there was ample room for improvement, this complacency began to fade and in its place emerged curiosity about what it would take to truly become the high-performing health system we believed we were.

We studied the limited literature voraciously, visited a number of high-performing health systems and brought their leaders to Saskatchewan to share their learning and approaches with a broad community of health system providers, managers and community leaders. These systems share in common much of what Kates and his colleagues write about: an unrelenting understanding of and commitment to patient-centredness; an unwavering focus on and crystal clear picture of their desired future state (and related commitment to measurement as the only means of determining progress on that journey); and full embrace and empowerment of those professionals closest to the work to redesign (and co-design with patients) how services are delivered. Each of these systems is incredibly thoughtful about the mechanisms and support required to achieve transformation. Perhaps the biggest gift these high-performing primary healthcare systems gave us was the
awareness that our primary healthcare system can and must do better, and that this will only be achieved through solid, longitudinal relationships between health providers and the individuals who use primary healthcare services, the broader communities in which they live and health delivery organizations.

As of late, we have been turning that curiosity inward. Last autumn, regional health authorities across Saskatchewan and other health system leaders assessed the current state of their primary healthcare services and identified both the gaps in quality and the pace of change required. This critical intelligence has set the foundation for applying the ideas and hopes expressed in our province’s new primary healthcare framework.

Collaboration: A Framework Built by Many Hands

Woven throughout the Kates et al. framework is the concept of teamwork – both explicitly, in terms of the healthcare team, and implicitly, through partnerships between providers and their patients, families and the broader community. In Saskatchewan, our Ministry of Health started the process by inviting over 400 people – community leaders, patients, providers, First Nations and Metis providers and patients, policy makers and managers – to help develop a framework for this province. This broad, collaborative approach was inspired by the success of the Patient First Review. We acknowledged that we could no longer contemplate changing and improving health services without involving those who use healthcare services as an equal participant in co-designing them.

Over nine months, this community of committed individuals crafted a shared vision for a sustainable primary healthcare system that will improve the patient experience and the health of our population. This group also described, in general terms, the actions required to realize this vision. The process they mapped out shares many similarities with the attributes in the framework from Kates and colleagues:

- High-functioning primary healthcare teams, with health professionals working to the top of their scope and the composition of the team driven by the health needs of the patients and their communities
- Service design rooted in the community and fuelled by partnerships among providers, communities and delivery organizations
- Quality improvement capability across the primary healthcare workforce anchored to the Institute for Healthcare Improvement’s Triple Aim approach, including ongoing and transparent measurement
- Flexible approaches to funding primary healthcare services, along with clear goals, expectations and accountabilities

Early on, we also heard directly from those who use primary healthcare that, in addition to working with providers and communities to co-design and improve services, they very much wanted to be in control of their own health and well-being. Working together in this way was new, and it appears to have provided the opportunity to build a vast array of trusting and
respective relationships and promises to serve as a catalyst for the work ahead.

**Capability for Continuous Improvement**

As Kates and colleagues note, a key supportive strategy for primary healthcare transformation is building continuous improvement capability among those who work in primary healthcare. The Health Quality Council has, through its learning collaboratives targeted at select chronic diseases, employed many of the approaches outlined in the framework. We will continue to apply them in the future through the Clinical Practice Redesign program (Health Quality Council 2012). Well over 30% of primary care physicians and their staff have acquired basic quality improvement knowledge, skills and experience. As Kates et al. note, much of this capability development within primary healthcare teams depends on providing them with local quality improvement coaches.

We also learned from our earlier quality improvement capability efforts that transformation demands more than simply providing support. A key element absent in our earlier endeavours was the expression of clear, system-wide improvement expectations and the attending accountabilities. Recently, Saskatchewan’s health system released its five-year strategic plan, which contains explicit goals, with corresponding targets and measures (Government of Saskatchewan 2012). We have never before had a clearer expression of what a transformed primary healthcare system should look like. Measuring progress on these ambitions is not optional. Efforts are well under way to enhance and develop data-collection systems that will inform individual primary healthcare teams’ improvement efforts as well as the public on the progress being made.

**Commitment: Broad and Enduring**

Large-scale change demands unwavering commitment from many partners. What sets Saskatchewan’s current effort apart from previous attempts to reform primary healthcare is the degree and breadth of commitment across our system. This has come from engaging hundreds of community leaders, patients, providers, First Nations and Metis providers and patients, policy makers and managers in the development of a true provincial framework. We have been very fortunate with the leadership and commitment our medical association has shown with respect to primary healthcare transformation, including the most recent president of the Saskatchewan Medical Association, who has been an unwavering and passionate champion. In addition to participating in and leading several primary healthcare–related committees, he uses blogs and Twitter to galvanize others (http://transformsask.blogspot.ca).

Government is showing its commitment by providing additional funding in 2012–2013 to support eight innovation sites; these prototype sites will test new models of care delivery using patient and community input and Lean methods to deliver services that best meet the needs of the patients, families and communities. We are optimistic that this learning-by-doing approach will help identify the best models and approaches to improve the access to and quality of services in our diverse mix of communities, which includes rural, remote, Northern, First Nations, inner city and urban. The province’s Health Quality Council is augmenting these efforts by focusing its...
Clinical Practice Redesign program to help build improvement capability within primary healthcare teams at these sites. This will ensure that patients’ access to and experiences with primary healthcare will improve, as will process efficiencies and workplace satisfaction.

**Courage**

Transforming primary healthcare challenges us to fundamentally rethink how we’ve always done things. There are significant challenges ahead that will demand even greater courage on the part of all stakeholders – governments, health regions, health professional groups, providers and communities. Long-standing issues, such as the need to align payment models with overall health system goals, will have to be addressed. Such challenges are never easy to work through; but the fact that we have strong, respectful relationships and transparent intelligence on health system performance should increase our chances of finding solutions.

**Conclusion**

Kates and colleagues’ framework has all the right ingredients for large-scale improvement in primary healthcare. Now comes the hard part: putting these elements into action. In Saskatchewan, we have already started this important work. We have the focused attention of our political, administrative and clinical leaders and obtained their commitment to finding opportunities that will accelerate improvement and to removing barriers that stand in the way. Our healthcare system is dedicating significant resources to building continuous improvement capability across its workforce using Lean methodology. Everyone with a stake in our health system – managers, providers and patients – is stepping up. Only time will tell whether we are successful. But there has never before been a time when we have collectively been filled with such hope.

**Acknowledgement**

We gratefully acknowledge the support of Greg Basky, director of communications and marketing at the Health Quality Council, in the review of the manuscript.

**References**


Canada’s Future Healthcare: Can It Be Better? Will It Be Better?

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ABSTRACT

Thought leaders envisage high-performing partnerships of engaged community practitioners, informed patients and non-professional caregivers collaborating continuously, and efficiently, to improve care and outcomes for whole patient populations. These primary care health social networks would be facilitated by needs-based training, meaningful measurements, sustained funding, effective leadership and integration with available resources and processes. Broadly voiced opinion supports such integrated, community-focused partnership and data-driven healthcare models, and a province-wide implementation of the model for acute and chronic cardiac diseases in Nova Scotia has conclusively demonstrated sustained improvements in clinical and economic outcomes. A reasonable hypothesis, then, is that such strategies will be rapidly adopted to effectively manage the primary care of our increasingly aged populations, with their large and recalcitrant gaps between usual and best care. However, there are impediments to widespread adoption in the short term, not the least being
In this issue of Healthcare Papers, Kates et al. (2012) outline key elements for a successfully operating primary care sector in a high-performing health system, including: partnerships of patients, families and community resources; a focus on enhanced stakeholder engagement; team-delivered, evidence-based and measurement-accounted practices; and support from adequate training, funding and governance. The ultimate goal is to achieve improved and sustained population care with accompanying beneficial health and economic outcomes.

**Today’s Situation**

Things can definitely be improved in Canadian healthcare. We have a rapidly aging population with an ever-increasing prevalence of chronic diseases (Ahmed et al. 2009), escalating costs and large care gaps, where usual care is often not best care (Medge et al. 2008; Montague 2004). For example, in Nova Scotia, women admitted to hospital for both acute and chronic cardiac conditions are about twice as likely as males to be elderly, poor and socially isolated, and consistently are less-often prescribed proven medical therapies (Montague 2004). The increasing burden of community-based patients with chronic disease is exacerbated by a current gap in the allocation of system resources – most major policy foci and funding have disproportionately targeted the institutional management of patients with acute diseases (Coutts and Sullivan 2012).

Another important health system gap is the paucity of measuring and communicating practices and clinical and economic outcomes as a means to continuously account current care and to foster improvements in future care (Chassin et al. 2010; Hébert 2010; Montague 2004). A related deficit is the slow development and uptake of facile electronic communication technology to aid the meaningful capture and communication of this relevant information for practitioners and patients (Ahmed et al. 2009; Blumenthal and Tavenner 2010; Brookstone 2010, April 12; Health Care in Canada Survey 2008; Montague et al. 2010).

**Visions of Integrated Care as Better Care**

We share the vision of Kates et al. for better population health via integrated care, with specific goals including a community network culture with aligned goals, collaborative values and infrastructure; team care with engaged physicians and other primary care practitioners; meaningful use of e-health measurement and communication technologies; professional stakeholder, patient and non-professional caregiver education in team theory and methods, and patient self-management; and, perhaps above all, the development of effective leadership skills that lead people to do what they might otherwise not do (Montague 2004, 2006; Montague et al. 2010; Nemis-White et al. 2011).

Similar visions of collaborative, patient-centric, community-oriented and measurement/communication-driven care have been proposed by other thought leaders as a means to improve population health, particularly for patients with chronic illnesses (Ahmed et al. 2010; Baker et al. 2008; Chassin et al. 2010; Coutts and Sullivan 2012; Hébert 2010; Holman and Lorig 2004; Huerta et al. 2006; Kriendler 2009). The opinions of front-line healthcare practitioners, administrators and the public have been less frequently reported.
Recently, however, the Health Care in Canada Survey bridged this void via representative samples of working physicians, nurses, pharmacists and health administrators as well as the adult general public (Ahmed et al. 2009; Health Care in Canada Survey 2008). The results confirmed that age-related chronic diseases are prevalent, affecting 65% of adults ≥65 years old. There was strong concordance, defined as ≥70% support or strong support among all stakeholders, for increasing investments for chronic disease management programs, patient self-management, practitioner-patient communication, more home and community care programs and more wellness promotion, prevention and education (Figure 1). Actual participation in ongoing disease management programs was reported by 34% of professionals and 25% of the public.

In a more recent survey of primary care practitioners in a major health region of Nova Scotia, 52% reported active participation in chronic disease management or collaborative practice incentives programs and 44% expressed interest in learning more about these programs (Nemis-White et al. 2011).

**The Practice of Integrated Care: A Case Study**

In 1997, a province-wide integrated model of disease management was launched in Nova Scotia. The initiative, called ICONS (Improving Cardiovascular Outcomes in Nova Scotia), had the basic objectives of improving and sustaining, in a cost-efficient way, the care and outcomes of all adult patients in Nova Scotia who had heart attacks, unstable angina or chronic heart failure. ICONS was characterized by community-based health networks, patient engagement, partnerships among health and related services, team-based care, performance measurement–driven quality improvement and innovation. The administrative structure included a project office and data coordinating centre, with governance by a steering committee that was reflective of all community, regional and institutional stakeholders, including hospitals, government, industry and patients and their advocates.

The key clinical structures in ICONS were community-based, multi-professional teams (primary care physician, nurse, pharmacist and medical specialist). Their principal roles included the provision of community leadership in creating and sustaining inter-professional and institutional-community networks; fostering patient enrolment; and facilitating knowledge translation among patients, profes-

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**Figure 1. Stakeholder support for increasing investments to help patients manage illness**

<table>
<thead>
<tr>
<th>Provider</th>
<th>Total Support</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public</td>
<td>72%</td>
</tr>
<tr>
<td>Doctors</td>
<td>75%</td>
</tr>
<tr>
<td>Pharmacists</td>
<td>82%</td>
</tr>
<tr>
<td>Nurses</td>
<td>83%</td>
</tr>
<tr>
<td>Managers</td>
<td>87%</td>
</tr>
</tbody>
</table>

Percent distribution of support or opposition among health professional and public stakeholders when asked their opinion on whether to increase investments to help patients manage their chronic diseases.

Source: Adapted from Health Care in Canada Survey (2009).
sionals and non-professional caregivers (Montague 2004; Montague et al. 2003). Building and sustaining these networks involved a focus on communication:

- Broad and repeated communication of clinical practices and outcomes
- Regular provider and patient educational newsletters, a program website, primary-care physician workshops, care maps, treatment algorithms and standardized hospital discharge order sheets
- Pharmacy-based compliance programs

Health social networks – especially with community-reflective, clustered lattice structures and overlapping of social ties, as in ICONS – can facilitate the rapid and broad spread of desired healthcare behaviours via frequent contact and redundancy and the reinforcement of influencing signals (Centola 2010). Coupled with the ICONS integration with provincial and regional government strategies, as well as patients and their advocacy organizations, the network design undoubtedly facilitated the enrolment of 2,000–2,500 patients per disease, per year, for five years. And it contributed to beneficial partnerships (Montague 2004, Montague et al. 2003) and clinical (Cox et al. 2008), macro-economic (Crémieux et al. 2007) and micro-economic (Paradis et al. 2010) outcomes.

There was continuous improvement in proven practices in all disease states, sustained even after ICONS evolved into an operational program of the Department of Health (Cox et al. 2008). There were also continuous decreases in one-year re-hospitalization rates, averaging approximately 20% for all patient populations.

The prescription of proven therapy was a positive predictor of survival at the individual level. The presence of conventional risk factors, such as increasing age and co-morbidity, were negative predictors; however, they were not predictors of readmission. Rather, the positive impact on re-hospitalization outcomes was more likely secondary to the community-reflective social network interactions in ICONS and the reinforcement of knowledge translation acting as effective therapeutic interventions (Centola 2010; Cox et al. 2008; Montague 2006).

**Figure 2. A perplexing care gap: persistent under-treatment of older patients**

![Graph showing prescription patterns of lipid-lowering therapy for all patients with acute myocardial infarction during ICONS (Improving Cardiovascular Outcomes in Nova Scotia; 1997–2002) and after ICONS became part of the Department of Health–funded provincial program Cardiovascular Health Nova Scotia. Despite the marked and sustained improvement in proven practice, and companion decrease in the overall prescription care gap, the care gap between younger and older patients was not eliminated.

Source: Reproduced with permission from Cardiovascular Health Nova Scotia, Nova Scotia Department of Health and Wellness.

**Impediments to Achieving Better Care**

So, if we have broad stakeholder consensus and a proven blueprint for cost-efficiently optimizing care at the population level, why
are we not already there? What is impeding us? Several things come to mind. One is that, despite the overall success of ICONS in improving care, older patients persistently received less proven therapy; and this practice pattern continues (Figure 2). In this era of patients living longer with age-related chronic diseases, the issue of possible age-bias as a contributing cause of care gaps assumes greater importance as an impediment to achieving optimal population healthcare and outcomes.

Another thought is that, although the Health Care in Canada Survey indicated pan-stakeholder support for many components of integrated care, there was a lack of concordant support for some key issues such as the value of team care, the roles of nurses and pharmacists, patient involvement in decision-making and the use of e-health technologies. And, of additional concern, the public and physicians, perhaps the two most influential stakeholders in the primary care universe, were consistently the least supportive of these concepts (Ahmed et al. 2009; Health Care in Canada Survey 2008).

In the more recent Nova Scotia regional survey, there was also evidence of dichotomies around integrated care issues (Nemis-White et al. 2011). While primary care practitioners supported team care at a level of 85%, there was a striking variance among practitioners in the valuing of specific characteristics of successful team care (Figure 3). Complementary skills, shared goals and shared care were highly and equally valued by all respondents. In contrast, measurements and communication of practices, outcomes, intra-team performance parameters and links between team performance and patient outcomes were valued much higher in theory by practitioners not in team care settings than by those actually working in care teams. This suggests that actual team membership may produce a sense that membership is the end goal and that there is no need for measuring and communicating practices and outcomes to drive continuous improvements in patient care. It may be an unintended, but adverse, practical manifestation of the “Romance of Teams” phenomenon (Allen and Hecht 2004).

Other potentially important impediments to the propagation of integrated care involve practitioner funding, interdisciplinary liability and leadership. For example, although practitioner-salaried models facilitate collaborative care, they are the exception among physicians (<8%) (National Physician Survey 2010). Fee-for-service funding models remain dominant in primary care, in both Nova Scotia and nationally. And since most non-physician practitioners support team care at a level of 85%, there was a striking variance among practitioners in the valuing of specific characteristics of successful team care (Figure 3). Complementary skills, shared goals and shared care were highly and equally valued by all respondents. In contrast, measurements and communication of practices, outcomes, intra-team performance parameters and links between team performance and patient outcomes were valued much higher in theory by practitioners not in team care settings than by those actually working in care teams. This suggests that actual team membership may produce a sense that membership is the end goal and that there is no need for measuring and communicating practices and outcomes to drive continuous improvements in patient care. It may be an unintended, but adverse, practical manifestation of the “Romance of Teams” phenomenon (Allen and Hecht 2004).

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primary practitioners cannot bill for their services, their salary and benefits largely come directly from the physician. It is easy to see that building a collaborative healthcare team of “equals” when non-physician members are dependent on a physician for their livelihood is challenging. Given an average overhead of 30% in fee-for-service practices, unless non-physician practitioners can generate additional revenue or have their salary offset by new funding sources, increasing investment by fee-for-service physicians for their services is unlikely.

Predicting the Future

Two key questions for the future are, how will the balance of promise and impediment likely play out? and, will integrated care become usual care? Applying a variant of game theory methodology may allow some predictive insight to address these questions (Thompson 2009, August 16). Briefly, the process involves

If we have broad stakeholder consensus and a proven blueprint for cost-efficiently optimizing care at the population level, why are we not already there?

Figure 4. Predicting the expansion of community-based disease management in Nova Scotia

Average predictive scores of a representative panel of community-based primary care practitioners and other experienced individuals in the Nova Scotia health system who were asked to assign a value for various key stakeholder groups in terms of their preference for, commitment to, power or clout to bring to fruition and resolve to stick with a decision to propagate integrated, community-based health and disease management across their province. RxD = innovative pharmaceutical industry; GOV = provincial government; RHAs = regional health authorities; NGOs = non-governmental organizations; MDs = physician practitioners; RNs = nurse practitioners; HOSs = hospitals; IMCs = integrated community medical clinics; PTs = patients; CGs = non-professional caregivers.
convening a panel of knowledgeable players in real-world practice and asking them to identify key stakeholders likely to exert influence on provincial-level decisions to propagate integrated health management along the lines delineated above. Panel participants then predict, in a secret ballot, using a five-point scale (1 = strongly negative and 5 = strongly positive), the position of each group of stakeholders on four key questions: (1) What is their degree of preference for integrated care? (2) What is their level of commitment to, or how hard will they work for, their preference? (3) What degree of power or influencing clout will they bring to bear in the decision process? (4) How resolved are these stakeholders or, conversely, how easily will they abandon their original preference?

Using this approach in late 2009 in Nova Scotia, a group of community-based practitioners and representatives of health academia, non-governmental organizations and industry were asked to focus on the likelihood of expansion of integrated disease management networks and projects across the province by 2011 (Montague 2011). The decision-influencing stakeholders rated were the provincial government, regional health authorities, hospitals, community clinics, non-governmental health organizations (e.g., the Heart and Stroke Foundation, Arthritis Society), physicians and other care professionals, non-professional caregivers, private industry and patients. The results of this exercise are summarized in Figure 4.

Briefly, the expert panel rated all stakeholders’ preferences as positive or strongly positive in favour of wide adoption of integrated health and disease management. The provincial government was recognized as the dominant enabling power in terms of decision-making, but was rated lowest in terms of commitment to work hard to enact and support the policy. In contrast, non-professional caregivers, patients and non-governmental organizations were rated as the most strongly committed and resolved to stick with the policy over time. Regional authorities, government and physicians were rated as the least resolved, or the most likely to move off their initial preference.

In the panel’s post-rating review and discussion of results, despite the universally supportive preference ratings, there was felt to be a low likelihood for the wide expansion of integrated health management networks over the two-year predictive time frame. This reasoning behind this consensus opinion was that the weight of favourable preference and high commitment among patients, caregivers and non-governmental organizations for integrated care development was not likely to outweigh the lesser preference, weaker commitment and resolve and greater decision-making clout of government.

Time has proven the prediction to be correct. Community-based health networks focused on team and measured care; facilitated by training, funding, effective leadership and governance; and integrated with other stakeholders and resources are not currently commonplace. And based on recent opinion, if the exercise were repeated today, it seems likely the prediction would be the same (Stephenson 2012, April 10).

Conclusions
Care can definitely be better. A growing body of opinion and empirical evidence
suggests that health social networks, including community-focused primary care, are effective at the population level. Support for such integrated care is broadly favourable, and proven models are available. However, significant impediments must be resolved, particularly inter-stakeholder differences in levels of preference and commitment for such changes. Active and visible leadership is the principal contributor to successful change (Ahmed et al. 2010, Prosci Inc. 2012). Inspiring and selfless leadership must generate heightened understanding of, and enhanced preference and commitment to, the societal value of integrated care among all stakeholders. If that leadership emerges, things will be better.

References


Now We Need a Framework for Action

COMMENTARY

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ABSTRACT

Over the past decade, there has been growing policy interest in the role of primary care within the Canadian health system, with the recognition that it has not been fully integrated and that its full potential has not been developed. The framework of Kates et al. starts to address some key organizational issues, by placing the patient, family and community at the centre of the healthcare system and by combining the Institute for Healthcare Improvement’s Triple Aim approach with the Institute of Medicine’s six improvement aims. What this framework does not do is provide a model of how to organize or deliver primary care or demonstrate how policy makers and those responsible for designing the healthcare system should structure organizational models, payment systems or accountability structures. Kates et al. have provided a useful first step. We now require a commitment to act.

Over the past decade, there has been growing policy interest in the role of primary care within the Canadian health system, with the recognition that it has not been fully integrated and that its full potential has not been developed (Rosser and Kasperski 1999; Starfield 2008). Concerns have included issues of access, coverage and quality, and since the late 1990s there have been attempts to reorganize and support developments in primary and community care.

In their paper, Kates et al. (2012) present a framework for supporting quality improvement in primary care. The authors rightly
argue that there is strong evidence supporting the importance of an effective primary care system as the foundation of an effective healthcare delivery system. This presents us with the questions of what an effective primary care system is, and what it might look like. These are not new issues; they have been discussed for several years and are being tackled in different ways in many countries.

How best to organize and deliver healthcare services is central to the operation of any health system; and while primary care is characterized as the first point of contact for patients and the place where care is initiated and co-ordinated, this provides no real clues to how it should be organized, who should deliver it, what activities should be provided and what skills practitioners should have. If there is a need to improve primary care, the direction of travel must be mapped out: we must establish both what high-quality primary care looks like and how we get there.

For policy makers and system managers, there is also the issue of how to ensure that appropriate high-quality services are delivered. How should primary care practitioners and organizations be incentivized and held to account for the services they deliver to the public?

While a clear and uncontested definition of quality primary care is perhaps unrealistic, there are specific components that have wide agreement. For example, Starfield (1998) identified four unique features of a primary care service: first contact access, person-focused care over time, comprehensiveness and coordination. Hogg et al. (2008) have suggested that other important aspects include patient-provider relationships as defined by communication, holistic care and an awareness of each patient’s family and culture. Hogg et al. also argue that primary care performance needs to be set within a broader structural environment that recognizes the wider healthcare system, the practice context and the organization of the practice. This reflects an increasing acceptance of the role of the healthcare delivery system, including issues of governance and accountability, person-centred care, and resources and interrelationships between primary care and other health and social care services (Starfield et al. 2005).

Some of these elements are found in Kates et al.’s framework, although perhaps a notable absence is that continuity of care is not a key characteristic of the framework even though it is arguably a significant indicator of quality. For example, in a review of outcome indicators for primary care, Sans-Corrales et al. (2006) found that improved satisfaction and health outcomes were associated with continuity of care, patient-centred care, longer appointments and a good patient-doctor relationship. These factors were also associated with lower overall health costs. Continuity of care is consistently reported as a key attribute and quality indicator of good primary medical care (general practice/family medicine) (Buetow and Entwistle 2011; Saulz and Albedaiwi 2004).

Nonetheless, the framework does start to address some key organizational issues. It is perhaps not surprising that at the centre of this framework, Kates et al. have placed the patient and the family – similar to most healthcare frameworks that see the patient at the centre of the healthcare system. What should be noted, though, is that in this framework

What does it mean for primary care practitioners to be advocates for their patients, and how far should practitioners monitor their patients’ behaviours and lifestyles?
the community is also placed at the centre as it influences individual health behaviour and status, as well as providing support and community networks for individuals and families. But what does this mean in practice? How should primary care interact with patients and their families? What relationship should primary care have with its local community?

These are important questions for policy and practice, and it is perhaps unfair to expect frameworks to answer all of healthcare’s complex questions. This is not the aim of the framework by Kates et al., which really sets out to provide a guide for primary care improvement. As such, the framework should enable those designing and working within primary care systems to ask the right kinds of questions and to set objectives and methods for improving the quality of primary care services. By combining the Institute for Healthcare Improvement’s Triple Aim approach with the Institute of Medicine’s six improvement aims, the framework provides a useful starting point for exploring improvement in primary care. It also presents significant challenges for those seeking to change and improve primary care services. But what this framework does not do is provide a model of how to organize or deliver primary care or demonstrate how policy makers and those responsible for designing the healthcare system should structure organizational models, payment systems or accountability structures.

The authors themselves shift between discussing primary care as a concept, the roles of primary care practitioners and the role of practices. This confusion of concept and practice is not uncommon in discussions of primary care and highlights some of the problems in both the definition of primary care and how policies about primary care can be operationalized. As I have argued elsewhere (Peckham and Exworthy 2003), primary care is something of a portmanteau concept. Yet the definition of primary care is important in that it is context specific. Thus, the organizational model becomes important within the context of the health system. For example, if you increase the access points for primary care by providing walk-in clinics, telephone contacts, pharmacy contacts etc., you increase the number of contacts with the health system. However, you

Visits to the main types of complementary practitioners constitute the equivalent of approximately 10% of all general practice consultations and should be considered as much a part of any primary care system as primary medical care itself.

While the evidence supporting greater patient engagement in healthcare is strong, similar supporting evidence is lacking for community-based primary care. Models and approaches vary from the community health models in South America and community-orientated primary care in South Africa and Israel, to medical models of community surveillance advocated by doctors such as Julian Tudor-Hart in the United Kingdom. All of these approaches take a population focus but provide fundamentally different models of care and provide challenging questions about the role of primary care as a forum for population surveillance, the monitoring of healthy people and the balance between primary and secondary prevention. For example, what does it mean for primary care practitioners to be advocates for their patients, and how far should practitioners monitor their patients’ behaviours and lifestyles (Fitzpatrick 2001)?
might not reduce inequalities in access. In fact, this may increase access for those who already use healthcare services (providing more choice) but not result in an increase in access for people who find this hard. More access points can also lead to less continuity of care. These are findings of recent research I undertook in the United Kingdom that examined the development of primary and community care services in a large urban environment.

For policy makers and system managers, there is the important issue of how Canadian primary care should be structured and funded. Are current payment systems appropriate, and do they provide the best use of resources for achieving the best patient care? Clearly, the framework does raise important questions about both the organization of care and how it is funded and incentivized. The call for blended payment systems is welcome in the Canadian context – recognizing that performance pay systems such as the Quality and Outcomes Framework (QOF) in the United Kingdom (a predominantly fee-for-service system) may not be appropriate within the wider fee-for-service context of primary care funding in Canada. But it is also important to acknowledge that other forms of incentives can affect the provision of primary care, including education and training, peer pressure and professional aspirations.

Despite such important shortcomings, the framework by Kates et al. does provide a starting point for engaging practitioners, patients and policy makers in a discussion about improving primary healthcare. Reflecting on the experiences in the United Kingdom, service improvements and innovations have been led by both policy makers and primary care practitioners – sometimes collaboratively, such as in the widespread evolution of various primary care networks, the development of new models of collaboration and the role of leading primary physicians in healthcare commissioning. The key point, however, has been the longstanding development in the United Kingdom of networks of practices, whether for teaching, research, commissioning, service planning or simple mutual support. Some innovations, such as networks of practices working with or acting as health service commissioners, have led to an opening up of practices (and individual practitioners) to the scrutiny of other primary care practitioners and local health service managers. This signifies a degree of trust that has resulted in local discussions about the quality of practice, inequalities in access and service delivery, and how best to meet local health needs. Kates et al. argue correctly that strategies for improving primary care will require support and assistance, and I encourage calls for training, increased resources and ensuring that good practice is shared. But these should not just be seen as top-down health system responses. Much of the drive for improvements in primary care can be driven by primary care itself by giving the practitioners the space, networks and autonomy to develop innovative responses to problems. Strategies of engagement, network support and resources for research and development in primary care will be crucial.

Primary care operates in a complex environment and in contexts with high degrees of uncertainty. Unlike specialist care, where there are often clear clinical certainties, primary care is immersed in the social context. The very definition of primary care is itself complex; and while we can list possible primary care practitioners, this is often done within the contextual constraints of the way we view our own healthcare systems. It is notable, for example, that in Kates and colleagues’ list of partners and team members, one key primary care service – oral health – has been left out (to be fair, an omission often observed in descriptions of primary care), despite oral
health problems being a significant problem for younger children and older adults. There is also a tendency to examine primary care through an allopathic medical lens. For example, in the United Kingdom, visits to the main types of complementary practitioners constitute several million consultations per annum—equivalent to approximately 10% of all general practice consultations—and should be considered as much a part of any primary care system as primary medical care itself (Peckham 2006).

In the end, frameworks are not models, nor are they prescriptive. Kates et al. have provided a useful first step in framing ways of thinking about primary care change. All those with an interest in primary care are beholden to use the parameters of the framework to start to ask questions about primary care practice and policy and to engage in a discussion about how it can be improved. However, despite calls to develop patient-centred care and responsive services, patients have not been significant players in primary care reform, and innovations in the United Kingdom have mainly been in the development of patient surveys. This is now gradually changing with the introduction of a small financial incentive for practices to establish patient reference groups. To place patients, their families and communities at the centre of the framework actually presents a significant challenge for practitioners and policy makers. However, working with these stakeholders will become increasingly important for primary care in order to address issues of public health, supporting people with long-term conditions and with multiple morbidities.

The World Health Organization report Primary Health Care – Now More Than Ever argued that good-quality healthcare combines effectiveness and safety with “person-centredness, comprehensiveness and integration, and continuity of care, with a regular point of entry into the health system” (World Health Organization 2008: 42). These are key features of primary care, and they are captured in the framework. But beyond everything, we now require a commitment to act.

References
The Authors Respond

Nick Kates, Brian Hutchison, Patricia O'Brien, Brenda Fraser, Susan Wheeler and Cheryl Chapman

ABSTRACT
The purpose of the framework we presented was to provide what Ellison (2012) describes as a vision for what the transformation of primary care is trying to accomplish (the Institute for Healthcare Improvement’s Triple Aim) and a road map for getting there. The framework identifies key characteristics of primary care practice and points to ways in which improvements can be introduced, while recognizing that there are many other system-level supports that need to be in place to enable this transformation. We saw this framework as a way to initiate further discussion about these issues, and this has been reflected in the thoughtful responses to our paper.

Support for the Components of the Model
It is heartening to see broad agreement among the commentators that the framework provides a useful starting point for thinking about ways to improve the quality of primary care, with several commentators presenting interesting ideas as to how the framework could be broadened.

Building on Previous Work
As a number of commentators point out, we have built upon and hopefully expanded the work of others who have defined the characteristics of primary care. All, like us, have started from the assumption that a well-performing primary care system is needed as the foundation of a high-performing healthcare system, although a number of authors, including...
Duckett (2012) and Peckham (2012), correctly identify the lack of true “systems” of primary care and the need to create these.

As Martin (2012) and Peckham (2012) point out, our work has been influenced by the work of Starfield (1998) and her four characteristics of effective primary care, the Patient-Centred Clinical Method developed by Stewart and colleagues (2003), the College of Family Physicians of Canada’s Four Principles of Family Medicine (1985) and, more recently, the World Health Organization’s 2008 report on primary healthcare.

Two Areas Addressed in the Paper
The commentaries address two broad areas covered in our lead essay. The first is transformation at the primary care practice/organization level, which is the focus of the framework and our proposed change strategies. The second are the external enablers required to facilitate this transformation and the necessary quality improvement work. Indeed, Ellison (2012) believes that several of these enablers need to be in place before the transformation work begins, if it is to succeed.

Saskatchewan and Nova Scotia
While most of the commentaries look at the paper from a higher-level systems viewpoint, Brossart and Donnelly (2012) in Saskatchewan and Nemis-White and colleagues (2012) in Nova Scotia describe initiatives taking place in their respective provinces and point out the applicability of the framework to the approaches they are using. Brossart and Donnelly identify four ingredients necessary to realize their vision in Saskatchewan that they feel map easily on to our framework. These are service design rooted in the community, quality improvement capability across the system, flexible approaches to funding and high-performing inter-professional teams.

Drawing upon the experience with community-based cardiovascular health networks, Nemis-White and colleagues highlight the importance of communication in building teams and partnerships, within the healthcare sector and between sectors, and put forward a number of creative ways this had been achieved in Nova Scotia.

Broadening the Model
Millar (2012) also supports the model but takes a broader view of primary healthcare, emphasizing the need for a strong community focus. He identifies six concepts for a broader vision of a community-oriented primary care system, which are consistent with the framework presented. These are a geographical population focus; patient and community engagement – a governance mechanism; comprehensive community-oriented primary healthcare services; collaborative inter-professional teams and partnerships; performance measurement and quality improvement; and innovation in financing. Partnerships and better collaboration are critical to this vision, as was the experience in Nova Scotia.

Peckham (2012) feels that continuity of care might be a missing factor in the framework. While not explicit in the framework, we took it as a given that continuity is integral to patient-centred primary care practice.

Contributions of the Model Presented
Five particular aspects of the framework are endorsed by the commentators: community
partnerships, patient engagement, measurement, the link to Triple Aim and team-based care.

Community Partnerships
The first aspect is placing the community at the centre of the model, alongside individuals and their families. Millar (2012) feels this can even go further and stresses the need for innovative and wide-reaching partnerships with community, including public health, to address social determinants of health. Nemis-White and colleagues (2012) and Brossart and Donnelly (2012) also comment on the benefits of strong community partnerships and input into decision-making, while Peckham (2012) identifies the many different models that have attempted to achieve this, often adapting principles to specific local contexts.

Patient Engagement
The patients and their families sit alongside the community in the centre of the model, and many of the commentators echo our point that the concept of patient engagement goes beyond just clinical partnerships to also involve patients in the design, evaluation and even governance of primary care service delivery. Ellison feels that moving from the concept of “patient” to “practice citizen” frees up primary care providers to explore new kinds of partnerships. Peckham (2012), while agreeing with the importance of seeing the patient and family at the centre of the model, cautions that actually doing this presents significant challenges but that it is increasingly important in managing complex and enduring conditions.

Measurement
The importance of measurement as part of any improvement work is emphasized by a number of commentators. Martin (2012) points out the challenge in changing the culture of primary care to one where measuring progress and outcomes becomes routine. The lack of information technology support that would facilitate the effective gathering, interpretation and use of data is also recognized as a major challenge, not only at the practice level, but also when measuring changes in the health of a community.

Link to Triple Aim
Another point of convergence is the link to the Institute for Healthcare Improvement’s Triple Aim as the outcomes to be pursued. Ellison (2012) feels that the Triple Aim’s focus on the health of populations could shift the thinking of providers and practices and drive some of the changes that would be required to move toward prevention and a community health focus – an idea espoused by both Duckett (2012) and Millar (2012). Ellison (2012) also comments favourably on the addition of the experience of providing care under the umbrella of enhancing the care experience within the Triple Aim.

Martin (2012) discusses the importance of measuring value and introducing this into the culture of primary care, feeling that one of the two key steps to ensuring the successful transformation of primary care is the inculcation of the vision and values encapsulated in the Triple Aim into the thinking and behaviour of all primary care providers (the symbolic and hortatory approaches).

Team-Based Care
Almost every response touches upon the
importance of flexible, well-coordinated teams. Duckett (2012) uses a sporting analogy to challenge us to think about the qualities of team performance we are looking for, again stressing the importance of flexibility in roles and tasks, while Brossart and Donnelly (2012) emphasize the need to involve those who are doing the work in the design and planning of the changes.

**Separation of Characteristics and Enablers**

The framework, and the paper, also attempt to differentiate between the dimensions of a transformed system of primary care at the practice/organization level and the enablers that will support these changes. While we concentrated on the micro level, most authors, especially Duckett (2012), highlight the need to have a variety of external factors in place if these changes are to succeed. Ellison (2012) also points out that ideally these need to be in place before the changes begin, although this is not always recognized by funders and planners.

**Enablers of Change**

While our intention in writing the paper was to present a framework for thinking about ways to improve primary care, we are aware that this cannot happen in isolation and that there are a number of key factors that need to be put into place.

**Authority**

Martin (2012) makes a strong case that if change is to be successfully implemented, it requires more than just incentives and capacity-building, allowing successful improvements to “flow” through a system and to stick. She identifies the need for clear points and lines of authority, with the local system, government and professional organizations all having a responsibility for ensuring that targets are identified and commitments followed up, what she refers to as the “vinegar.”

**Infrastructure**

Many commentators identify the importance of “infrastructure” – referred to either as local governance mechanisms or an integrated system of care – as another mechanism for encouraging provider participation and community focused care. Infrastructure also allows for the provision of mutual support, exchange of ideas and sharing of resources, within an agreed-upon plan, while reporting on a common set of measures and indicators to track performance. The emerging divisions of family practice in British Columbia clearly reflect this sentiment.

**Leadership**

While infrastructure is clearly a key enabler, most of the commentaries also mention directly or indirectly the importance of effective and visionary leadership in bringing about these changes. This leadership needs to come not only from within the practices but also from the broader healthcare community, professional and academic organizations, and local-, regional- and provincial-/territorial-level governing bodies.

**Other Enablers**

There is also strong agreement about the importance of other enablers, including stable funding for all team members, not just physicians, and funding models that support the goals of improving primary care and that promote quality and safety. The need for alignment between system-level goals and practice-level changes is stressed in many of the responses. Martin (2012) and Ellison (2012) both comment on the importance of training future providers to work in these kinds of models, and Ellison points out that many physicians are unfamiliar with quality improvement (QI) methods and need assistance to implement the new concepts, including training and coaching.
The issue of physician engagement is a critical one in all QI initiatives, acknowledged explicitly by Brossart and Donnelly (2012).

**Implementation**

Ellison (2012) and Peckham (2012) point out that primary care practices are complex adaptive systems, and this presents some specific challenges when introducing change or innovation. Change is not always linear, and it needs to have simple rules and clear overall goals, while allowing ideas to develop. Both Ellison (2012) and Martin (2012) also discuss the psychology of behavioural change and the need to support and assist with the changes in habits and practices required by all primary care providers to take full advantage of the new approaches.

**Conclusion**

Together the commentators make a series of helpful contributions to the discussion about a new framework for improving primary care, with their endorsement of our overall approach, their suggestions for expanding the framework we presented and their pertinent observations about the importance of external enablers. This spirited exchange has advanced our underlying goal of promoting discussion about how to strengthen primary care in Canada.

**References**


Child Health in Canada

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