THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

# The Patient's Medical Home Provincial Report Card

## Report Card—February 2019

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This report card reflects current performance but is a living document. If provincial government performance in an area changes, we will alter that area's spotlight in a future report.




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# Keeping Canada Healthy

From coast to coast to coast, everyone living in Canada should have access to the same high level of health care. As guided by the Canada Health Act, provinces and territories are responsible for delivering health care services, with the mandate of ensuring equitable care across the country. However, needs, demographics, and resource availability vary across Canada.

Not all provinces and territories have equal resources—their populations are different, and so are their health care needs. It is up to provincial and territorial governments to provide their communities with accessible care that is comprehensive, proactive, and timely.

The roles and responsibilities for health care services are shared between provincial and territorial governments and the federal government. The provincial and territorial governments are responsible for managing, organizing, and delivering health care services. The federal government is responsible for: setting and administering national standards for the health care system through the Canada Health Act; providing funding support for provincial and territorial health care services; supporting the delivery of health care services to specific groups; and providing other health-related functions.

As the voice of family medicine, the College of Family Physicians of Canada (CFPC) supports the federal government in its work to bring Canadian provinces and territories together in our publicly funded health care system. The Patient's Medical Home (PMH) model is a made-in-Canada vision that embraces Canadian values of equity, fairness, and access to care for all people.

This document evaluates the performance of the 10 PMH pillars for each province based on past, current, and future initiatives that have been/will be implemented. Each area is graded on a scale of green, yellow, or red, as follows:

GREEN

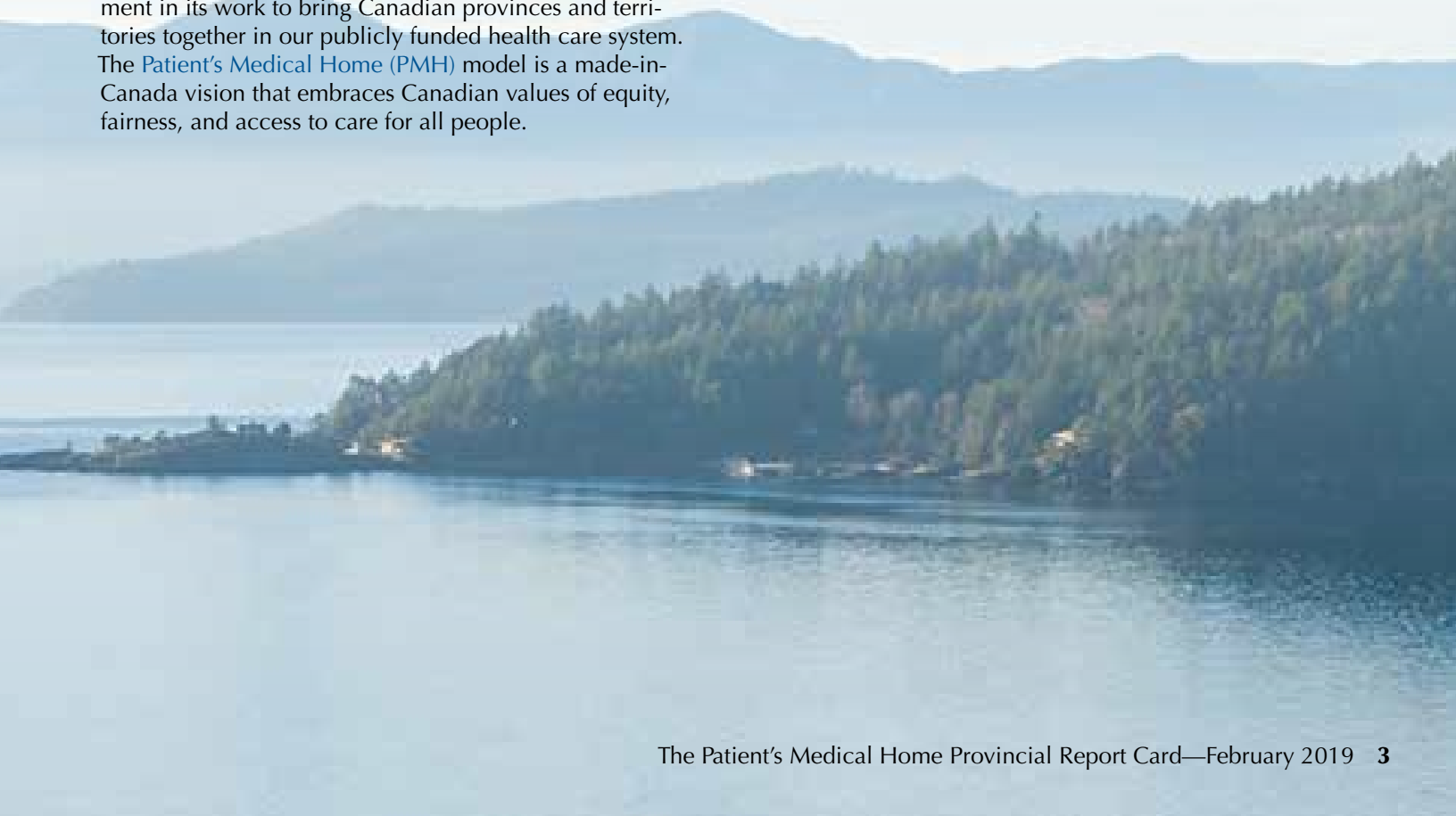
- **Green:** the provincial government is demonstrating strong leadership; we encourage an ongoing commitment in these areas

YELLOW

- **Yellow:** the provincial government is somewhat involved or has indicated an intent to act but could do more

RED

- **Red:** the provincial government has shown no involvement; there is a need for immediate attention. A red grade is a call to action!



# The Patient's Medical Home

In this vision, every family practice across Canada offers medical care that is seamless and centred on an individual patient's needs, within their community, throughout every stage of life, and integrated with other health services. The PMH model is evidence-based, and results in care that increases patient and provider satisfaction, improves timely access, reduces the number of emergency department and after-hours clinic visits, and enhances chronic disease management.
Find out more at www.patientsmedicalhome.ca

## Why PMH?

- Supports family physicians to provide highest-quality patient care
- Optimizes working conditions to support recruitment and retention
- Enables primary and community care efficiencies through collaborative interprofessional teams
- Reflects and responds to the changing needs of Canadians within the context of their own communities
- Supports the relationships between patients and family physicians and other health care providers
- Enables the best possible health outcomes for each person, practice population, and the community being served

| The PMH pillars | | |
|---|---|---|
| 1 | **Patient-centred care** | A PMH provides care that is focused on the individual patient and tailored to their specific needs. |
| 2 | **Personal family physician** | The patient's own family doctor, the most responsible care provider, is at the core of the PMH. |
| 3 | **Team-based care** | A PMH offers a broad scope of services carried out by a multidisciplinary health team, including the patient's personal family physician. |
| 4 | **Timely access** | A PMH ensures timely access to and coordination with appointments within the practice. The PMH also coordinates timely appointments with services outside the practice. |
| 5 | **Comprehensive care** | A PMH provides each patient with comprehensive family practice services, and meets and supports the public health needs of the community. |
| 6 | **Continuity of care** | A PMH provides continuity of care, continuity of relationships, and information for patients. |
| 7 | **Electronic medical records (EMRs)** | A PMH maintains and meaningfully uses EMRs for its patients. |
| 8 | **Education, training, and research** | A PMH serves as an ideal site for training medical students, family medicine residents, and those in other health professions. It is also an ideal setting for medical research. |
| 9 | **Evaluation and quality improvement** | A PMH regularly evaluates the effectiveness of its services as part of its commitment to continuous quality improvement (QI). |
| 10 | **Internal and external supports** | A PMH has internal support from practice-appropriate administration, and external support by governments, the public, and other health professionals. |

# Summary

Here is how the provinces are performing in the PMH pillars.

| | Patient-Centred | Personal Family Physician | Teams | Timely Access | Comprehensive Care | Continuity of Care | Electronic Medical Records | Education, Training, and Research | Evaluation and Quality Improvement | Internal and External Support |
|---|---|---|---|---|---|---|---|---|---|---|
| AB | | | | | | | | | | |
| BC | | | | | | | | | | |
| MB | | | | | | | | | | |
| NB | | | | | | | | N/A | N/A | |
| NL | | | | | N/A | N/A | | N/A | N/A | |
| NS | | | | | | | | | | |
| ON | | | | | | | | | | |
| PEI | | | | | | N/A | | | N/A | |
| QC | | | | | | | | | | |
| SK | | | | | | | | | | |

| | Total Population[1] | Average Age of Population[1] | Health Spending Per Capita[2] | Percentage of Population Without a Personal Family Physician/Regular Health Care Provider*[3] | EMR Use[4] |
|---|---|---|---|---|---|
| AB | 4.3M | 36.7 | $7,329 | 18% | 87% |
| BC | 4.8M | 42.1 | $6,321 | 16% | 85% |
| MB | 1.3M | 37.4 | $7,182 | 16% | 80% |
| NB | 760,000 | 45.3 | $6,643 | 10% | 63% |
| NL | 530,000 | 45.7 | $7,378 | 10% | 65% |
| NS | 950,000 | 44.6 | $6,996 | 10% | 78% |
| ON | 14.2M | 40.6 | $6,367 | 10% | 86% |
| PEI | 150,000 | 43.5 | $6,633 | 11% | — |
| QC | 8.4M | 42.2 | $6,434 | 26% | 77% |
| SK | 1.2M | 37.0 | $6,982 | 19% | 79% |
| CANADA | 36.7M | 40.6 | $6,604 | 16% | 82% |

*A regular health care provider is defined as a health professional that a person sees or talks to when they need care or advice about their health. This can include a family doctor or general practitioner, other medical specialist, or nurse practitioner.

# Provincial report cards

## Alberta

### 1. Patient-centred care

Alberta Health Services (AHS) is Canada's first and largest province-wide, fully integrated health system. The main objective of the Patient First Strategy (2015) is to strengthen AHS culture and practices to ensure patients and families are at the centre of all health care activities, decisions, and teams. AHS achieves this by promoting respectful patient/provider interactions; improving communication between providers and patients/clients/families; adopting a team-based approach to care; and improving transitions in care. AHS created a toolkit to help health care providers understand the benefits of engaging patients and their families when planning their care.

YELLOW

### 2. Personal family physician

Ensuring Albertans are connected to a primary care provider is a commitment that the government and health authority are strongly dedicated to accomplishing. There are three ways to find a family doctor in Alberta: 1) through the College of Physicians and Surgeons of Alberta online tool; 2) through the Primary Care Networks; or 3) through Health Link Health Advice 24/7.

The Central Patient Attachment Registry (CPAR), launched in 2018, is a centralized database listing primary care physicians or nurse practitioners and their paneled patients. Continuity of care is an essential element in implementing the PMH. The CPAR will enable better continuity of care for Albertans by facilitating improved relational continuity, information continuity, and data for health care planning purposes. Eighty per cent of Albertans are currently attached to a family physician.

YELLOW

### 3. Team-based care

Collaborative practice is a priority for primary care networks (PCNs) and AHS. Approximately 80 per cent of primary care physicians are registered in a PCN. For each patient registered with a PCN, $62 helps fund collaborative team members. Each PCN chooses how this funding is distributed. Established in 2003 through the Primary Care Initiative, there are 41 PCNs operating throughout Alberta with more than 3,800 family physicians, and more than 1,000 other health practitioners.[5] At any given time, there are hundreds of PCN family doctors accepting new patients. Under the new primary care governance structure, AHS and PCNs will work together to ensure team-based care is enabled in every community.

GREEN

### 4. Timely access

Alberta Access Improvement Measurement (AIM), a provincial organization funded by AHS, looks to support teams to create a culture of improvement by accessing evidence-based data that result in care that is timely and effective.[6] Alberta AIM works with teams to measure indicators such as panel/case load size, demand/supply/activity, and patient/staff/provider satisfaction.

PCNs are also reducing wait times and the use of emergency departments by providing extended and after-hours service (including 24-hour clinics).

YELLOW

### 5. Comprehensive care

Most PCNs offer comprehensive care, with teams made up of family physicians and other health care professionals, such as nurses, dietitians, mental health professionals, pharmacists, and therapists. PCNs provide services to almost 3.6 million Albertans, and services are tailored to best meet the needs of the population or community being served. Core primary health care service delivery

includes chronic disease prevention and management, palliative and end-of-life care, maternal and child health services, addiction and mental health services, and minor emergency care.[7]

GREEN

## 6. Continuity of care

Alberta's Primary Health Care Integration Network is "focused on improving transitions of care between primary health care providers and acute care, emergency departments, specialized services and other community services. This will ensure Albertans get the care and social supports they need in the communities where they live."[8]

The Alberta Medical Association received funding to launch a continuity campaign with clinics built around the implementation of CPAR, which encourages the attachment of patients to their identified medical home.[9] The initiative improves continuity of care for Albertans by facilitating better relational continuity, information continuity, and data for health care planning purposes.

In June 2017 family physicians overwhelmingly agreed to governance changes for PCNs. The changes will ensure that each PCN develops a specific community-based service plan. Service plans will help ensure there is better service coordination so PCNs can work with AHS and patients to meet the unique health needs in each region of the province.

The Health Quality Council of Alberta provides measures of system performance including indicators of relational continuity. Over the past three years the rates of relational continuity have increased across the province.

GREEN

## 7. EMRs

Alberta has one of the highest adoption rates of EMR use in Canada (85 to 90 per cent). With a high provincial adoption rate, the government's goal has shifted to integrating practices' primary care data into one system.

Alberta Netcare is the provincial electronic health record (EHR) designed for authorized health professionals to share key patient information and improve the quality of patient care. There is no method for direct access by patients at this time. However, a project is currently under way to develop a personal health portal function within MyHealth.Alberta.ca to allow Albertans to view information in the provincial EHR. The EHR includes information such as medication details, laboratory test results, diagnostic images and reports, hospital visits, surgeries, and drug alerts.

GREEN

## 8. Education, training, and research

AHS's Primary Health Care Resources Centre[10] is a one-stop online tool for all information related to primary health care. The Physician Leaders' network supports physicians with tools and resources for adopting a PMH model.[11]

AHS has partnered with the Canadian Medical Association's Physician Leadership Institute to offer leadership development opportunities. They also have other learning and education opportunities, such as the Learning Resource Navigator (LeaRN), physician leadership development, clinical development opportunities, and the Quality and Patient Safety Curriculum.[12]

Initiatives such as the AHS Provincial Simulation Program (eSIM)[13] enable learners to practise and master individual and team skills to improve patient safety and enhance the quality of care. The eSIM program supports training for physicians and staff involved in delivering care to patients using two primary services: simulation practice readiness centres (PRCs; training facilities that recreate virtually any care environment), or mobile simulation (specialized vehicles and portable equipment used to support educators who do not have access to a PRC).

Enhancing Alberta Primary Care Research Network is an infrastructure to support and enhance Alberta's existing practice-based research networks (PBRNs) as well as academic and community

# Alberta

practitioners in conducting primary care research. Research projects supported by this network have informed health policy in Alberta.

GREEN

## 9. Evaluation and quality improvement

The Health Quality Council of Alberta promotes and improves patient safety and health service quality province-wide, primarily through the lens of the Alberta Quality Matrix for Health.[14]

Formed in 2009, the Physician Learning Program (PLP) supports physician learning by providing practice data and feedback reports to individual physicians. The PLP obtains, analyzes, and presents health systems data, and collaborates with various agencies across Alberta to create learning opportunities for physicians.[15]

The PCN Program Management Office is a program within the Alberta Medical Association that provides operational and business administrative support services to PCNs, as well as tools and resources to support PCNs in communications, evaluation and quality, and business planning.[16]

GREEN

## 10. Internal and external supports

The release of the 2014 Primary Health Care Strategy established the principles and strategic directions for continued transformation of primary health care in Alberta. This includes what needs to be done to further enhance the delivery of care, to change the culture within the system, and to put in place the building blocks for long-term sustainability. In 2008 Alberta was the first province to centralize its health system. AHS is a province-wide, fully-integrated health system, responsible for delivering health services to the over four million people living in Alberta, as well as to some residents of Saskatchewan, British Columbia, and Northwest Territories.[17]

Baseline block funding for PCNs is determined by the number of physicians in the network and the number of patients attached to these physicians—a funding model that blends capitation and payment-per-provider. PCNs are also paid $62 per capita that supplements costs such as administration, equipment, rent, chronic disease management programs, and 24/7 access. AHS pays grant funding to PCNs for non-physician health providers. There is no allocated funding for nurse practitioners, so they are paid through the PCN's operational budget.[18]

The 2018 budget announced $248 million to support primary health care.[19]

GREEN

# British Columbia

## 1. Patient-centred care

Providing patient-centred care is the first of eight priorities for the British Columbia health system as articulated in the Ministry of Health's strategic plan, *Setting Priorities for the B.C. Health System*.[20] The strategic plan states that the province will strive to deliver health care as a service built around the individual, not the provider and administration. The government understands this is not an overnight change but looks to sustain a focus that will drive policy, service design, training, service delivery, and service accountability systems.[21] In 2015 the Ministry of Health released the *British Columbia Patient-Centred Care Framework*.[21] The framework presents four patient-centred care practices to help guide organizations in pursuit of patient-centred care: organization-wide engagement; workplace culture renewal; balanced patient-provider relationships; and tool development.

The Patient Voices Network is a community of patients, families, and caregivers that works with health care partners to include the patient perspective in problem solving and decision making to improve British Columbia's health care system.[22] The General Practice Services Committee (GPSC) also developed a patient experience tool that has been launched in 25 practices. It allows patients to answer questions about their own care, and information is then used by the practice and the system as a whole.

YELLOW

## 2. Personal family physician

Building on the 2010 Attachment Initiative, the Government of British Columbia and Doctors of BC, through the GPSC, started the province-wide A GP for Me initiative in 2013. The program objectives were to improve service delivery, ensure patients are full participants in their own care, and provide a family doctor for every British Columbian who wants one.

The program ended on March 31, 2016. Overall, A GP for Me brought over 400 new doctors to British Columbia communities; attached almost 180,000 people to a doctor, including previously unattached vulnerable patients; and prevented over 130,000 patients from becoming unattached by transferring them from a retiring or relocating doctor to a new doctor.[23] As currently written, the proposed contracts appear to undervalue the skills that family physicians bring to their role as most responsible provider and as such may not be an appealing choice for practitioners considering their professional options. Perceived inconsistencies in the proposed contracts contributes to the risk of creating two tiers of family physicians.

British Columbia plans to address the shortage of general practitioners in the province by providing funding for up to 200 new general practitioners to work in the new team-based care model, and offering opportunities for every family medicine resident to work in a renewed primary care system that allows them to focus their time and energy on practising patient-centred medicine.[24]

The 2018 British Columbia budget committed $150 million to connect those who do not have a family doctor with team-based primary care.[25]

YELLOW

## 3. Team-based care

The British Columbia government's new primary care strategy is focused on expanding team-based care through PCNs. These networks will be the backbone of the team-based approach, allowing patients access to a full range of health care options from maternity to end-of-life, streamlining referrals from one provider to another, and providing better support to family physicians, nurse practitioners, and other primary health care providers.[25] PCNs are system level change versus working within the doctor's office.

The province is creating 200 new nurse practitioner positions to support patients as part of a shift to a team-based primary health care system,[26] and 50 new clinical pharmacist positions as part of PCN teams around the province.[27] It remains to be seen how these new positions will be deployed to support patients within the PCN/PMH, or if they will contribute to further fragmentation of care.

In April 2017 the Ministry of Health announced $150 million in new funding over three years to bring integrated team-based primary care services to more communities throughout British Columbia.[28]

YELLOW

# British Columbia

## 4. Timely access

The 2018 primary care strategy introduces urgent primary care centres. These centres will provide primary care to patients who currently do not have a family physician or nurse practitioner, and weekend and after-hours care, taking pressure off hospital emergency departments. A total of 10 centres will be established over the next year.[25]

The Practice Support Program (PSP) includes learning modules, such as Advanced Access and Office Efficiency, which aim to improve a practice's workflow and make it easier for patients to book an appointment without an extended wait.[29]

YELLOW

## 5. Comprehensive care

The 2018 primary care strategy introduces PCNs and community health centres.[25] The PCN will provide patients access to a full range of health care options. The community health centres will link health and broader social services to improve access to health promotion, preventive care, and ongoing services. Each of these centres will be designed and developed independently, in line with the needs of their communities and fully integrated into local PCNs.[25]

The province must ensure that subsequent waves of PCN implementation pay closer attention to integration and comprehensiveness of the care team supporting PMHs, rather than focusing on attachment as a sole measure.

The Family Practice Incentive Program encourages coordinated, longitudinal care by supporting and providing guideline-informed care in such areas as chronic disease management, maternity care, mental health, and care for the frail and elderly.[30]

In 2017 British Columbia established a Ministry of Mental Health and Addictions to address the addiction and overdose crisis.[31]

YELLOW

## 6. Continuity of care

The newly developed urgent primary care centres are intended to network with family practices to ensure seamless transition of information and care between them. The Family Practice Incentive Program also provides coordinated, longitudinal care by supporting and providing guideline-informed care in such areas as chronic disease management, maternity care, mental health, and care for the frail and elderly.[30]

YELLOW

## 7. EMRs

British Columbia aims to optimize their EMRs by using the functionalities to better understand their patient panels, and use the data to inform their practices. Most health authorities are working to create a seamless transition of information from family practice EMRs to hospitals.

Pathways[32] is a web-based directory that connects family doctors and other specialists to streamline referrals. The program was developed by the Fraser Northwest Division of Family Practice, where it was piloted successfully, and is now accessible to family doctors and residents across the province.

The Doctors Technology Office is a program funded jointly by the Doctors of BC and the British Columbia government through the GPSC. It provides centralized support to physicians and other Doctors of BC partner programs, to address the needs of the physician community for coordination and enhancement of EMR functionality and interoperability, technology solutions and support for complex IT technical issues, and centralized data management and reporting needs.[33]

Although much progress has been made with the uptake of EMR use, more government support is needed to further the functionality, sustainability, and meaningful use of electronic tools.

GREEN

# British Columbia

## 8. Education, training, and research

The new primary care strategy specifically supports family medicine residents. Through the provincial health authorities, graduating medical residents and nurse practitioners can start their careers within primary-care networks in team-based practices on alternative payment arrangements, instead of the traditional fee-for-service (FFS) payment plan. This change was made in response to a survey by the Society of General Practitioners of British Columbia, which found a majority of resident doctors feel that changes are required in how primary care is delivered and that alternative physician-payment models could promote the delivery of comprehensive patient care.[34]

A major initiative by the GPSC was establishing The Divisions of Family Practice, which involved forming 35 local networks of family physicians to address common health care goals, find new strategies on which to collaborate, and serve over 230 communities.[19]

The GPSC has developed online tools and resources to support doctors and divisions of family practice with their patient medical home work. There are also opportunities for hands-on programs such as Maternity Care for BC, which promotes, supports, and trains British Columbia family physicians to reconnect with low-risk maternity services through mentorship, hands-on experience, and financial support.[35]

GREEN

## 9. Evaluation and quality improvement

The BC Patient Safety and Quality Council, established in 2008, provides system-wide leadership for efforts designed to improve the quality of health care in British Columbia. Through collaborative partnerships with health authorities, patients, and those working within the health care system, they promote and inform a provincially-coordinated, patient-centred approach to quality.[36]

The Health Data Coalition (HDC)[37] is a physician-led data sharing initiative that encourages self-reflection and facilitates QI in patient care. The HDC platform connects EMR data used by primary care physicians across British Columbia by automatically and securely transferring core sets of standard aggregated data from an EMR system to its web-based application.

The PSP[38] is a QI-focused initiative that provides a suite of evidence-based educational services and in-practice supports to improve patient care and doctor experience. The PSP supports doctors to work toward an integrated system of care via the PMH model.

A PMH evaluation framework is currently being created. Transparency of governance and data use will require close attention. There needs to be a commitment to a just culture of data use to protect provider/patient safety and autonomy.

YELLOW

## 10. Internal and external supports

There are five regional health authorities in British Columbia and a provincial health authority responsible for province-wide initiatives (including a number of agencies).[19] FFS is the main compensation model, with alternative payments becoming more common and now representing about 20 per cent of overall available funding for physician service.[39] Physicians can also receive funding through rural practice programs, which focus on recruiting and retaining physicians in rural practice, and through the Medical On-Call Availability program, which compensates physicians for being on call.[40] The GPSC addressed pay issues by developing a range of new incentive payments to help full-service family doctors deal with the increasing demands of family medicine in 2003, including the family practice incentive program.[41]

The GSPC is a strong supporter of the PMH and has taken the PMH as the vision for the model for care.

In May 2018 the government announced the launch of a new primary health care strategy to deliver faster and improved access to health care for British Columbians in all parts of the province.

Although progress is being made, more resources are still needed to support the overall vision of the PMH, including modifying the current FFS model.

YELLOW

# Manitoba

## 1. Patient-centred care

The Manitoba government is transitioning from eight independent health organizations to one, called the Shared Health Services Manitoba. The goal of this transition is to improve patient-centred care. It allows services to be pulled from specific areas, so they can be accessed by patients that are not necessarily living in urban centres.[42]

YELLOW

## 2. Personal family physician

The government created a family doctor plan, with a goal that by 2015 every Manitoban would have access to a family doctor and primary care team. Manitoba has taken several steps to support both the 2015 goal and the longer-term vision of how family doctors practise. Registering with the Family Doctor Finder program helps Manitobans connect with a primary care provider. To date, 95 per cent of Manitobans without a family physician who registered for the program have been matched with a doctor.

More progress is being made regarding accurate patient enrolment/identification of who each patient's primary provider is.

GREEN

## 3. Team-based care

My Health Teams (also known as PCNs), are currently being developed.[43] The My Health Teams were preceded by the Physician Integration Networks that started in 2006. Budget 2018 announced that a total of 15 My Health Teams are being set up across the province; 11 are operational and now providing services to patients.[44]

The Interprofessional Team Demonstration (ITD) initiative was established to create collaborative interprofessional teams within FFS clinics. In spring 2013 the Winnipeg Regional Health Authority, together with Manitoba Health and Healthy Living and Seniors, began to implement the ITD. The initial goal was to start with a small number of clinics (the early adopters) to pilot the processes necessary to engage practices and implement this initiative, which would permit for revisions and refinements in future recruitment phases.

Both initiatives must demonstrate clear deliverables, including showing that patients are getting better access, physicians seeing more patients, and so on.

GREEN

## 4. Timely access

Manitoba Health is adopting advanced access scheduling. It supports participating clinics with a variety of resources, including written materials; access to a facilitator to help the team set goals, take measurements, report, hold meetings, and complete team development work; access to faculty and other participants for information sharing and problem solving; and access to measurement tools for help with spreadsheets, data collection, and panel identification.

My Health Teams provide patients with access to primary care within 24 to 48 hours at their regular clinic. Time spent in waiting areas for appointments may be reduced.

YELLOW

## 5. Comprehensive care

My Health Teams are committed to providing comprehensive, person-centred care, that will support and help patients access accurate health care information to help them make informed choices about self-care across the lifespan, and focus on prevention and their overall wellness, not just treatment and illness. Teams will set program and service priorities and goals based on the needs of their local communities. For example, a team might decide to focus on communication between doctors and home care nurses. Another team may decide to work together to provide mental health services in a different way.

YELLOW

# Manitoba

## 6. Continuity of care

The Home Clinic model[45] has been introduced to help support both primary-care providers and their patients. The model provides practices with insight regarding their enrolled patient population, completeness of patient demographic and clinical data, as well as comparative data to show how a clinic is performing in relation to other Home Clinics. In the future, Home Clinics will be able to share essential clinical information about their enrolled patients with episodic care providers and, in return, receive information regarding episodic care provided to enrolled patients. This continuity of information will be valuable to all health providers involved, and to the enrolled patients.

YELLOW

## 7. EMRs

Launched in October 2010, the EMR Adoption Program[46] offered funding to help 1,000 community-based physicians in primary- and specialist-care clinics in Manitoba to implement EMRs in their practices. The number of community-based clinicians using approved EMRs grew from about 30 per cent when the program was introduced to more than 73 per cent using approved EMRs today. However, there have been issues regarding the government approval of particular EMR brands, as original certified EMRs are no longer receiving updates.

Established in 2008, the Primary Care/Community Information Systems Office was developed to support the adoption and effective use of EMRs and other technology by physicians and other clinicians in primary care and community-based specialties throughout Manitoba.[47] The office manages provincial standards for EMRs and supports a peer-to-peer support network for physicians wanting to adopt EMRs.

YELLOW

## 8. Education, training, and research

The government is supporting family medicine residents, especially in rural areas.

The Medical Student/Resident Financial Assistance Program, established in 2001 and revamped in 2010, offers $12,000 to medical students for each of their years in medical school, plus additional grants if they establish a practice in the province. In return, students are required to work in an underserviced part of the province for six months for each year they received the grant.

The Home for the Summer program, operated by Manitoba's Office of Rural and Northern Health, pays medical students to work in clinics and hospitals throughout Manitoba to gain valuable experience.[48]

Manitoba Health has also pledged funding to Family Medicine Interest Group activities.[49]

RED

## 9. Evaluation and quality improvement

The Primary Care Information System manages the Primary Care Data Extract,[50] a specific set of data elements being submitted by over 130 primary care and community clinics in Manitoba. Data extracts help support planning, delivering, and evaluating primary care services and programs throughout the province.

The Manitoba Primary Care Information Collaborative and Primary Care Data Repository is partnership of primary health care stakeholders, Manitoba Health, and Manitoba eHealth. They work together to ensure that EMR data submissions result in value-added information and reporting for all primary care stakeholders.[51]

YELLOW

## 10. Internal and external supports

The 2018 Budget included the most financial support ever for Manitoba Health, Seniors and Active Living, at $6.2 billion, including $3.89 billion for front-line care provided by the regional health authorities and funding for PCIS.[52]

YELLOW

# New Brunswick

Note: New Brunswick had an election September, 2018. Changes in policy and programs may occur with government changes.

## 1. Patient-centred care

In 2012 the New Brunswick government released the Primary Health Care Framework, the vision of which is "better health and better care with engaged individuals and communities."[53] The framework notes that this vision will be achieved through improved integration of existing services and infrastructure and the implementation of patient-centred primary health care teams working collaboratively with the regional health authorities to meet identified communities' needs.[53]

More recently, the government announced the integration of three key health services: Ambulance New Brunswick, the Extra-Mural Program (home care program), and Tele-Care 811. This change was implemented to help manage patients' primary health care needs and improve patient-centred care.[54]

The New Brunswick Family Plan, announced in 2017, calls for better access to patient-focused care by using interdisciplinary teams as part of an integrated treatment framework.[55]

YELLOW

## 2. Personal family physician

The government established Patient Connect NB—a provincially-managed, bilingual patient registry for New Brunswickers who do not have access to a primary health care provider (family doctor or nurse practitioner).[56] New Brunswickers without a provider can register and are assigned on a first-come, first-served basis. Despite the implementation of this registry, a 2017 patient survey from the provincial Health Council found that about 10 per cent of residents do not have a family doctor.[57]

In January 2017 the government launched the New Brunswick Family Plan, aiming to improve the lives of all New Brunswickers by addressing factors that are the biggest determinants of overall health. It includes seven pillars, the first of which is improving access to primary and acute care.[58]

In February 2018 the government announced the addition of 25 new primary care physicians and six nurse practitioners to the health system.[59,60] It is expected that this addition could result in 20,000 more New Brunswickers having access to a family doctor and thereby nearly eliminating the current wait list. According to the Minister of Health, in the past three years 327 doctors have been hired in New Brunswick, resulting in a net increase of 93 (45 are family doctors).[61] No current action has been made to implement these additional primary care physicians into the health system. However, once supports are made, this indicator will transition to a Green grade.

Physicians in a community-based family practice that has been established for more than one year can also use a "chart initiation fee" billing code ($50 per visit, times three visits) when accepting a new permanent patient on their roster.[62]

YELLOW

## 3. Team-based care

In the early 2000s community health centres (CHCs) were established in New Brunswick. CHCs are composed of an interprofessional team that includes family physicians, nurses, dietitians, social workers, and rehabilitative therapists. There were nine CHCs across the province in 2012.[18]

The 2017 New Brunswick Family Plan focuses on improving access to team-based care. Moving toward this goal, the government announced a partnership with the New Brunswick Medical Society to establish a voluntary program called Family Medicine New Brunswick. In this model, physicians have their own rosters of patients, but also provide a service to all patients of doctors on their team.[63] In May 2018 the government announced that 10 new family doctors will be coming to work in Fredericton under the model.[61]

Despite these efforts, the New Brunswick Medical Society reports that only 16 per cent of physicians in the province are working in interprofessional practices.[64]

YELLOW

# New Brunswick

## 4. Timely access

According to the New Brunswick Medical Society, New Brunswick's doctors have some of the highest patient loads in the country: for example, 1,800 patients per family physician, compared to 1,000 patients per physician in Quebec. Only 30 per cent of patients can see their doctor for a same-day appointment.[64] In fact, a 2017 patient survey found that 41 per cent of patients waited more than five days for an appointment with their family doctor.[57]

The New Brunswick Family Plan aims to improve the lives of all New Brunswickers by addressing factors that are the biggest determinants of overall health. The first of the seven pillars is improving access to primary and acute care.[58]

In February 2018 the Premier announced $25 million in new targeted investments to fund a multi-year plan to reduce wait times in the health system.[65] Specific initiatives include hiring new family physicians and other specialists to increase access to primary health care, increasing the number of nurse practitioners to increase access to primary health care, and introducing eConsult.

In the program, doctors are encouraged to see patients quickly, improving timely access. Participating clinics offer extended hours, including weekends. If a patient's own doctor is unavailable, they will be able to see a different physician who has full access to medical information.[66]

The Why Wait campaign was launched in 2017 and is a partnership with family medicine, nurse practitioners, local pharmacists, Tele-Care 811, and after-hours clinics. The purpose of the campaign is to raise awareness about the various health care options available to patients in the Moncton area in an effort to reduce congestion and wait times in the hospital's emergency department.[67]

YELLOW

## 5. Comprehensive care

Comprehensive care is one of the key goals in the Primary Health Care Framework for New Brunswick (2012). Team-based care is described as a key mechanism for improving access to comprehensive care.

In February 2018 the government announced the introduction of eConsult to better connect primary care providers and specialists.[65] This is a new form of electronic consultation between primary care providers and medical specialists that improves access and ensures that comprehensive, quality care is provided.

There are incentive billing codes that have been implemented to recognize the additional work required by family physicians beyond that of a regular office visit—including when providing guideline-based care to patients with selected qualifying chronic diseases—such as chronic disease management and chronic obstructive pulmonary disease.[62]

YELLOW

## 6. Continuity of care

The 2017 New Brunswick Family Plan calls for family physicians to play a leading role managing a person's overall health care access. A system focused on preventive and primary care in the home and the community will lead to healthier New Brunswickers. Each person's health is better managed through regular access to a primary health care provider who knows the patient's history rather than depending on episodic care in the emergency department or walk-in clinic.

The Extra-Mural Program is a province-wide program that was relaunched in January 2018 under new management. Family physicians refer patients to the program, which delivers interdisciplinary home care from teams of nurses, respiratory therapists, occupational therapists, physiotherapists, social workers, and other health professionals.[18]

RED

# New Brunswick

## 7. EMRs

According to the New Brunswick Medical Society (NBMS), New Brunswick has one of the lowest rates of adopting EMRs in the country.[68] Currently, supports that are available for EMRs are provided by the NBMS, in partnership with federal and provincial programs.[68]

Velante (launched by the NBMS) is the only approved EMR system in New Brunswick to be part of a family health team and the only one with granted accessibility to the patient's test results (Meditech). The two per cent rise of billing code 1 (office visit) for Velante users has caused some concerns as this is seen as disadvantageous for physicians doing an equivalent job but not using Velante.

RED

## 8. Education, training, and research

Limited information is available.

**Recommended grade: N/A**

## 9. Evaluation and quality improvement

Limited information is available.

**Recommended grade: N/A**

## 10. Internal and external supports

Presently, 70 per cent of doctors in New Brunswick are remunerated through the FFS model.[69] However, changes to payment schemes are being considered. Physicians working in Family Medicine New Brunswick Groups (through the Family Medicine New Brunswick Program) will receive 60 per cent of remuneration through capitation and the remaining 40 per cent through FFS.[70]

The 2018 Budget announced that the health care budget in New Brunswick would increase by 3.7 per cent, bringing it to $2.75 billion for the 2018/2019 fiscal year. The department's budget has increased 9.8 per cent since 2014/2015.[71]

YELLOW

# Newfoundland and Labrador

## 1. Patient-centred care

In 2015 the Newfoundland and Labrador government released *Healthy People, Healthy Families, Healthy Communities: A primary health care framework for Newfoundland and Labrador*. The third goal of this multi-year strategy is ensuring "timely access to comprehensive, person-focused primary health care services and supports."[72]

The government acknowledges the importance of patient-centred care, and there are currently ongoing developments being made to create a new framework, although nothing has been released publicly.

YELLOW

## 2. Personal family physician

There is no provincial program in place to help patients find a family physician. Instead, doctors accepting new patients can be identified through the Newfoundland and Labrador Medical Association (NLMA)'s website.[73]

RED

## 3. Team-based care

The *Healthy People, Healthy Families, Healthy Communities* document made team-based care a key priority. The framework called for patients and families to be attached to a collaborative primary health care team, or health home.[72] The second goal of the framework is "primary health care reform should work to establish teams of providers that facilitate access to a range of health and social services tailored to meet the needs of the communities they serve."[72]

So far, primary health care teams have been introduced in St. John's, and are planned for Corner Brook and Burin.[74]

YELLOW

## 4. Timely access

Timely access is also a priority in *Healthy People, Healthy Families, Heathy Communities*. Specifically, the framework calls for expanding same-day, after-hours, and weekend access to health care providers and services, and better use of technologies to make health services more convenient and accessible for patients.[72] While the intent has been signaled, not much action on this aspect of the PMH has happened in the past few years.

A 2016 Commonwealth Fund survey[75] ranked the province lower than national averages for timely access. For example, 34 per cent of residents secured same- or next-day appointments with a doctor or nurse (43 per cent national average), and 16 per cent easily accessed care evenings, weekends, or during holidays (non-emergency department visits; 34 per cent national average).

RED

## 5. Comprehensive care

Limited information is available.

**Recommended grade: N/A**

## 6. Continuity of care

Limited information is available.

**Recommended grade: N/A**

# Newfoundland and Labrador

## 7. EMRs

In Newfoundland and Labrador, eDOCSNL is the provincial EMR program for physicians jointly governed by the NLMA, the Department of Health and Community Services, and the Newfoundland and Labrador Centre for Health Information.[76]

The eDOCSNL program costs are shared between the provincial government (70 per cent) and participating physicians (30 per cent).

YELLOW

## 8. Education, training, and research

Limited information is available.

**Recommended grade: N/A**

## 9. Evaluation and quality improvement

Limited information is available.

**Recommended grade: N/A**

## 10. Internal and external supports

The 2018 Budget announced a $6.5 million cut to the $122 million Salaried Physician Services Budget, which the NLMA says may have significant impact on patients in rural areas of the province, whose providers may be on salary.[77]

Although progress is being made in some areas, the budget cuts and lack of transparency and communication have left physicians feeling less supported.

RED

# Nova Scotia

## 1. Patient-centred care

In 2017 the Nova Scotia Health Authority (NSHA) released *Strengthening the Primary Health Care System in Nova Scotia*. This guiding document outlines future directions for primary care in Nova Scotia, including a focus on patient-centred care and establishment of health homes.[78]

Teams are encouraged to understand the population they serve. Data are being shared, but are currently geographic and not available at the team-based level. Team agreements require teams to complete QI projects; some teams have created a patient advisory council as one of their QI projects. The NSHA continues to collect data at the municipal, cluster, and network levels, but clarifies that these data do not provide insight into the needs of an individual practice panel. The NSHA views patient councils as helpful in achieving this goal.

The NSHA is currently conducting a research project focused on understanding the costs and benefits to a practice of having a patient council.

YELLOW

## 2. Personal family physician

Nova Scotia introduced the Need a Family Practice Registry for people not attached to a family practice. As of July 2018 there were 50,000 registrants not yet placed with a family practice (5.4 per cent of the Nova Scotia population).[79] Since the registry was launched in November 2016, 10,501 people have found a primary care provider.[80]

In recent years the government has made specific budget commitments for recruiting and retaining physicians. The 2017/2018 budget committed an additional $2.4 million to support that goal,[81] and the 2018/2019 budget included $19.6 million as part of a $39.6 million multi-year plan.[82]

The government has taken a number of steps to recruit and retain family physicians. In March 2018 it announced a $6.4 million Patient Attachment Incentive Trust—a program that offers a financial incentive of $150 for each patient a family doctor takes off the provincial list, or who is referred from an emergency department, or who is without a family doctor.[83] Since April 2018, 319 doctors have submitted claims, taking on a total of 2,893 new patients.[84] One month later, through a partnership with Dalhousie University, the government introduced the Practice Ready Assessment Program—a recruitment program that will assess internationally trained family doctors for work in Nova Scotia—with an investment of $1.3 million.[85] Finally, the government announced revisions to the provincial financial incentive program, to allow all physicians moving to any communities in Nova Scotia to apply for several compensation packages (prior to this change, only physicians moving to rural communities were eligible for such incentives).[86]

YELLOW

## 3. Team-based care

The *Strengthening the Primary Health Care System in Nova Scotia* report recommended 'health home'—a model based on interprofessional collaborative family practice teams. The vision of this model is based on a population health approach that focuses on wellness and chronic disease management, and incorporates team-based care.[18]

There are approximately 50 collaborative family practice team locations in Nova Scotia in various stages of development, supported by the NSHA and the Department of Health and Wellness.[87] Nova Scotia is also home to Primary Care Teams (PCTs), which were in place prior to 2014. PCTs vary in their services offerings and interprofessional team composition, which may include physicians, nurse practitioners, midwives, dieticians, counsellors, public health nurses, and other health care providers. PCTs negotiate funding with their respective District Health Authorities; some physicians are salaried and others are FFS.[18]

The 2017/2018 budget committed $6 million to advance new collaborative care teams across the province, increasing access to family doctors, nurses, and other primary care providers for thousands more Nova Scotians.[81]

YELLOW

# Nova Scotia

## 4. Timely access

In December 2017 Premier Stephen McNeil wrote that timely access to care is a top priority for the government of Nova Scotia.[88] Since then the government has been making investments to address this challenge. In March 2018 the government announced the addition of 39 new health professionals to health care teams in the province to help improve timely access to care.[89]

The NSHA is tasked with finding a balance between maintaining and supporting a work/life balance for family physicians, while attempting to place over 50,000 unattached patients in the care of a primary care provider.

The NSHA is encouraging change through the health home team co-leadership agreements, which lay out how teams works together. Teams must demonstrate a clear plan for enhancing access, adding capacity to the team, and/or adding new patients. The NSHA wishes to develop a clear and transparent methodology on panel size.

YELLOW

## 5. Comprehensive care

The NSHA is conducting policy planning work on an ongoing basis regarding comprehensive care. Several years ago the Department of Health and Wellness rolled out the Model of Care Initiative in Nova Scotia, which was aimed at determining an appropriate team mix on acute care units. This model is not currently established but is under development for a clearer methodology.

There is also a focus on connecting the mental-health care system and primary care. Mental-health care workers could be funded by the mental health and addictions portfolio, and function as members of the team in areas where there is significant need. The mental health program is currently undergoing a health services planning exercise.

In March 2018 the government announced the addition of 39 new health professionals to health care teams to support the provision of comprehensive care.[89]

YELLOW

## 6. Continuity of care

The NSHA is seeking funding from the Department of Health and Wellness to support physicians who work in team-based care, to have time for face-to-face conversations, hallway consultations, and meeting time to build teams. This will require additional attention as it was not popular among physicians and the billing is complex.

The health home model supports an environment where a patient may be seen by someone other than their most responsible provider at each visit. This builds relationships with other team members who also have access to the patient's record.

YELLOW

## 7. EMRs

Approximately 60 per cent of family physicians in the province use EMRs. However, according to Doctors Nova Scotia, the province does not have an effective way to share medical records among health care providers, hospitals, and medical zones. Doctors Nova Scotia has called on the government to ensure that medical records, including One Patient One Record (OPOR) and MyHealthNS, are integrated and shared among providers.[90]

MyHealthNS allows all Nova Scotians to sign up for a personal health record, offering an online tool that gives patients secure access to health information any time, anywhere, using a computer, smartphone, or tablet.[91] Announced in 2016, OPOR is a long-term plan to consolidate the various clinical information systems used by health care professionals across the province.[92]

# Nova Scotia

The Primary Health Care Information Management program, the Department of Health and Wellness, and District Health Authorities/IWK Health Centre support a province-wide EMR system. This makes robust EMR tools available to a diverse group of providers including family doctors and other specialists, collaborative emergency centres, nurse practitioners in long-term care, hearing and speech clinics, hepatitis C clinics, and more.[93]

In March 2018 the government announced a pilot project to encourage physicians to use technology when engaging with patients. They established $4.2 million for a technology incentive that provides participating family physicians up to $12,000 a year for using technology to communicate with patients and share information by telephone and through e-health services. They also announced $8.5 million for an EMR Incentive Trust and Support Fund, which will provide a one-time payment for family doctors changing EMR providers and financial support for EMR users.[83]

YELLOW

## 8. Education, training, and research

The NSHA has identified five or six health home sites for clinical teaching. A lot of training and preceptorship is happening across the province in both health homes and non-health home clinics. Strengthening teams in medical training locations is a priority, as well as health system research. The NSHA employs a Director of Research who meets with interested teams and engages in outreach.

These sites involve students in research projects, which has the added benefit of teaching medical and health profession research systems and operations. The program also includes informatics training, and many other student tracks link through the NSHA Director of Research.

GREEN

## 9. Evaluation and quality improvement

The NSHA provides QI tools for health care practitioners in the province.[94] The government's Health System Quality Branch is responsible for driving health care improvement with leadership to guide and drive QI across the health system, as health quality knowledge brokers, and as leaders in the science of health QI.[95]

The NSHA is part of Accreditation Canada, so some health home teams go through primary care standard accreditation. Teams are encouraged to be ready to engage in this process, but it is not a requirement at this time.

YELLOW

## 10. Internal and external supports

Nova Scotia recently introduced a Family Medicine Bursary, which provides residents with $60,000 to establish a family practice in exchange for a three-year commitment to practise in the province.[86]

In 2015 Nova Scotia established two health authorities, the NSHA and the IWK Health Centre. The NSHA is gradually implementing primary care teams (health homes), which reflect the principles of the PMH. They provide access to family physicians through a team setting that includes other providers, such as nurse practitioners who are also providers of ongoing primary care with access to family physicians as required.

In Nova Scotia most family physicians are paid via FFS or through a guaranteed income Alternate Payment Plan. Doctors Nova Scotia released a position paper outlining recommendations that included updating physician remuneration models in order to improve access to care for all Nova Scotians. Doctors Nova Scotia currently has a working group developing a blended payment model; the Nova Scotia College of Family Physicians is actively involved in this planning process. The blended payment model is anticipated as an important component of negotiations with the government in the coming year.

YELLOW

# Ontario

Note: The provincial election occurred in June, 2018. Policies and programs may change as a result of government changes.

## 1. Patient-centred care

The Patients First Act, passed in December 2016, puts patients at the centre of the health system, and requires that every Local Health Integration Network (LHIN) has a patient and family advisory council and/or citizen panel.[96]

Approximately 30 per cent of Ontarians are in a team-based primary care organization, many of which have patients on their Board of Directors. Patient experience surveys are being rolled out with Health Quality Ontario and are becoming the norm across teams.

In December 2012 the Ministry of Health and Long-Term Care (MOHLTC) launched community Health Links pilot projects—a patient-centred approach to care that focuses on creating seamless care coordination for patients living with complex conditions—that have now been implemented across all LHINs.

Pilot programs across Ontario are connecting patient records across the health care continuum; however, this feature is not currently available province-wide.[97] There are also pilot programs that give patients access to their medical records. For example, MyChart is owned and operated by Sunnybrook Health Sciences Centre in Toronto but is used at a number of hospitals across Ontario, including Hamilton Health Sciences Centre, William Osler Health System in Mississauga, The Ottawa Hospital, Lakeridge Health in Durham Region, and Michael Garron Hospital in Toronto.

Although progress has been made at the pilot program level, Ontario would benefit from having one province-wide strategy unifying various projects.

YELLOW

## 2. Personal family physician

In December 2016 the MOHLTC announced that "94 per cent of Ontarians now have a primary care provider."[98] Through Patients First: Action Plan for Health Care, Ontario is committed to connecting a family doctor or nurse practitioner to everyone who wants one. As per Health Care Connect (up to June 2017), 91.4 per cent of Ontario patients are registered with a primary care clinician; the highest LHIN is 98.7 per cent (Hamilton Niagara Haldimand Brant).[99]

GREEN

## 3. Team-based care

In Ontario, there are 184 family health teams (FHTs), 74 CHCs, 25 nurse practitioner-led clinics, and 10 Aboriginal health access centres that provide comprehensive primary care to more than 3.5 million Ontarians in over 200 communities across the province (25 to 30 per cent of Ontarians).[100] Approximately 25 per cent of family physicians practise in family health organizations/family health networks as part of FHTs.

The 2017 budget dedicated $248.4 million over three years to support existing teams, including recruiting new staff, retaining current health care workers, and creating new care teams across the province, so that every region in Ontario has at least one team.[101]

YELLOW

## 4. Timely access

Patients are able to access a doctor during extended evening and weekend hours for urgent problems. In addition, patients can use the FHT Telephone Health Advisory Service, where a registered nurse provides advice about urgent health care concerns.[102]

# Ontario

One of the four main priorities of Patients First: Action Plan for Health Care is improving access and providing faster access to the right care.[103] Specifically, changes supported by this legislation will improve access to primary care for people in Ontario, including a single number to call when they need health information or advice about where to find a new family doctor or nurse practitioner. It will also improve local connections between primary care providers, interprofessional health care teams, hospitals, public health, and home and community care to ensure a smoother patient experience and transitions.[96]

According to a 2016 Fraser Institute report, Ontario had the shortest wait times for medical procedures in the country, with median wait times more than four weeks shorter than the national average.[104] However, less than half of the Ontario population aged 16 years or older were able to see their family doctor, or someone else in the office, on the same day or next day when sick.[105]

YELLOW

## 5. Comprehensive care

There are various primary care models implemented in Ontario, including FHTs, CHCs, enhanced FFS, family health groups (FHGs), and comprehensive care models (CCMs). Both the FHG and CCM models act as an incentive by directing additional funding to family physicians who are providing comprehensive primary care to their patients and emphasizing illness prevention.

YELLOW

## 6. Continuity of care

There remain some system challenges and barriers in certain settings that limit the ability to address continuity of care, including EMR adoption, the use of emergency departments and walk-in clinics, and transitions in care through patient handovers and referrals.

Health Quality Ontario has produced a guidebook, *bestPATH,*[106] that includes a multi-year initiative for improving health outcomes, the experience of care, and system effectiveness for Ontarians with complex chronic illness. The consistent application of effective practices is still a challenge across the province.

YELLOW

## 7. EMRs

In August 2015 OntarioMD, a wholly-owned subsidiary of the Ontario Medical Association, assumed responsibility for delivering new EMR programs and related services to physicians using certified EMRs. It will continue to administer legacy EMR funding programs. Oversight for all EMR programs and services also transitioned from eHealth Ontario to the MOHLTC.[107] According to OntarioMD, more than 14,000 physicians have enrolled in their services.[108] A current challenge is integrating the existing EMRs across the system. Many of the financial incentives for physicians to adopt EMRs are no longer available.[109]

Many pilot programs and initiatives happening across Ontario look to connect patient records across the health system or give patients access to their own medical records, including the connecting South West Ontario Program and MyChart.

YELLOW

## 8. Education, training, and research

The Health System Research Fund (HSRF) will fund policy-relevant research across the province. The HSRF is based on the MOHLTC's research strategy, established in 2008 and updated in 2012. The HSRF identifies areas such as home and community care, health system performance and sustainability, and QI and safety, as strategic priority research areas. Equity, patient-centred care, and modernizing patient-centred care through digital health are cross-cutting components.[110]

The Institute for Clinical Evaluative Sciences (ICES) research program, Primary Care and Population Health Research, will examine the accessibility and effectiveness of primary health care and issues in population health.[109] INSPIRE-PHC (INnovations Strengthening PrImary Healthcare through REsearch) is an overarching program focused on primary health care, which includes research, support, and network components to serve the primary care health research community.[111]

GREEN

# Ontario

## 9. Evaluation and quality improvement

Although Health Quality Ontario (HQO) has provided a range of documented QI resources for specific pilot initiatives, the level of support for primary care to engage in QI is limited, with little to no compensation to engage physicians who are not in teams. In addition, HQO provides comparable data on primary care performance indicators across the province as well as QI reports at a practice level, which require individual physicians to engage in additional work to link to their patient-level data to inform any QI activities.

The IDEAS (Improving & Driving Excellence Across Sectors) program is a partnership of HQO, ICES, the Institute of Health Policy, Management, and Evaluation at the University of Toronto, as well as seven Ontario universities. IDEAS provides a broad, evidence-based QI training program for Ontario's health professionals.[113] The program's goal is for participants to become skilled in a common language and approach to QI, with the explicit aim of improving patient care, experience, and outcomes. Penetration of this program into primary care has not been high.

YELLOW

## 10. Internal and external supports

FHGs and CCMs are payment models in Ontario's Primary Care Renewal program that provide remuneration in addition to the FFS payment model.

Expanding interprofessional primary care teams in areas with the greatest need is the biggest priority, so that people in all regions of the province have access to team-based primary care. Only 25 per cent of physicians practising in Ontario are in teams.

YELLOW

# Prince Edward Island

## 1. Patient-centred care

Health PEI (established 2010) is the province-wide health care provider responsible for delivering publicly-funded health care services including hospitals, health centres, public long-term care nursing facilities, and community-based programs and services. Patient-centred care is noted in Health PEI's strategic goals, specifically Goal 1: "provide Islanders with safe, quality, person-centred care and services."[114]

Health PEI offers patient-centred programs for patients. For example, the Patient Navigator Service helps individuals and caregivers access and coordinate needed health and social services and supports, and allows patients to play a more active role in self care.[115]

YELLOW

## 2. Personal family physician

In 2017 Health PEI reported that 96 per cent of Islanders had a primary care provider and noted that the province was home to a record number of physicians. Nonetheless, in that same year close to 7,000 residents were still waiting to be assigned to a family doctor or nurse practitioner.[116]

The Patient Registry Program connects Islanders with family physicians or nurse practitioners who are accepting new patients.[117] After implementation of the registry and a concurrent effort in the province to recruit health professionals (mainly nurse practitioners), 7,400 people were matched to primary care providers over a two-year period (from 2011 to 2013).[18]

In the Budget Address 2018 the Prince Edward Island (PEI) government announced the addition of two new family physicians in the central part of the province to support Islanders who are having challenges accessing primary care and community mental health care.[118]

GREEN

## 3. Team-based care

Primary care is provided through five PCNs. Each network has a team of health care professionals including family physicians, nurse practitioners, registered nurses, diabetes educators, licensed practical nurses, clerical staff and, in some cases, dietitians and mental-health care workers.[119] Within the five networks, there are 12 individual health care centres providing patient care. PEI also has family health care centres established under the federal Primary Care Transition Fund at an annual cost of $6 million. Family health care centre team members include physicians, nurse practitioners, nurses, counsellors, community workers, social workers, and dieticians.[18]

In 2010 Health PEI introduced the province-wide initiative Collaborative Model of Care. The model was designed to facilitate health care professionals working together in a collaborative environment where they have opportunities to use their skills, knowledge, and training to deliver safe, high-quality health care. This approach was designed to ensure health human resources are used effectively and efficiently, by empowering various health professionals to take on larger roles in the health sector (e.g., registered nurses, licensed practical nurses, and patient care workers). Since its introduction, more than 25 sites (including hospitals, long-term care homes, primary care offices, etc.) have implemented the model.[120]

The PEI government is continuing to support the expansion of team-based care. In the Budget Address 2018, the government committed to adding nurse practitioners to collaborative family practices in order to improve access to community-based care.[118]

GREEN

## 4. Timely access

Health PEI has been working to reduce wait times for primary care. They report that that wait times for accessing primary care physicians have improved from an average of approximately 22 days in 2014/2015 to fewer than seven days in 2015/2016.[18]

# Prince Edward Island

One of the main approaches to easing the burden on family physicians and improving timely access to care in PEI has been the addition of nurse practitioners to the health system.[121] In addition, patients without a primary care provider or those who are unable to make appointments with their primary provider can visit one of PEI's walk-in clinics to access care.[122]

YELLOW

## 5. Comprehensive care

PCNs in PEI offer a comprehensive array of services including diagnosis, treatment, education, disease prevention, and screening.[119] Primary care providers also collaborate in at-home care for frail seniors through the COACH program (Caring for Older Adults in the Community and at Home). The COACH program is led by a team of health professionals, including a geriatric program nurse practitioner, the patient's primary care provider, and a home care coordinator.[123]

Outside of the primary care practice, PEI offers a number of other services for patients (e.g., mental health and sexual health walk-in clinics).

YELLOW

## 6. Continuity of care

Limited information is available.

**Recommended grade: N/A**

## 7. EMRs

PEI is working to implement a province-wide EHR. According to Health PEI, the province is among the leading jurisdictions of EHR deployment and adoption in Canada.[124] However, despite these efforts, currently there is no effective EMR solution that can be used province-wide. Addressing this issue is a key step in ensuring all clinics are using EMRs, including the advanced functionality.

As of March 31, 2014, PEI had invested $28.9 million in their EHR system.[124] This funding has been focused primarily on hospital-based systems, without similar support for primary care EHR integration. Planned future developments should be realized successfully to deliver integrated, high-quality care for residents. It will also be important to ensure electronic records are available and interoperable province-wide across the health care system, including in primary care.

RED

## 8. Education, training, and research

PEI offers a medical education program to provide opportunities for undergraduate and visiting post-graduate medical students to gain experience in family medicine (and other specialties) in health care facilities across the Island.[125] Through this program, PEI is a training site for students at Dalhousie University, Memorial University of Newfoundland, and University of Sherbrooke. Learners at other Canadian and international universities must direct their requests through the Association of Faculties of Medicine of Canada's Student Portal.[125]

Through a partnership with Dalhousie University, PEI has a family medicine residency training program. The program has four residency training seats for graduates from Canadian medical schools, and one residency seat for a graduate from a recognized medical school outside the country.[126]

Practising physicians in PEI looking to pursue specialty training or gain new clinical skills can access assistance through return-for-service contracts of the Clinical Skills Fellowship Fund.[125]

YELLOW

# Prince Edward Island

## 9. Evaluation and quality improvement

Limited information is available.

**Recommended grade: N/A**

## 10. Internal and external supports

According to Health PEI, prior to April 2016 two-thirds of the Island's family doctors were salaried (i.e., were paid a flat rate regardless of the number of patients seen). There was a period of time when new physicians hired in two major cities, Charlottetown and Summerside, were only allowed to be paid FFS; however, they now have an option to be in a salaried position.[127] The Prince Edward Island College of Family Physicians is concerned that this one-size-fits-all approach will negatively impact recruitment and retention of family physicians in these communities.[128]

YELLOW

# Quebec

Note: The provincial election occurred in October, 2018. Policies and programs may change as a result of government changes.

## 1. Patient-centred care

The Groupes de médecine de famille (GMF) is a team-based care model that most closely resembles that of the PMH. In a GMF, each doctor takes care of the patients who are registered with them, but all the doctors who are members of the same GMF can access all the medical records for the GMF. This means that if someone comes in for a consultation and does not have an appointment with their own doctor, they can be seen by another available health care provider, including another physician, a nurse, a social worker, or another health care professional.

GREEN

## 2. Personal family physician

Family physicians are at the core of all care provided by GMFs. As of April 2017 there were more than 302 GMFs in Quebec, with 40 new GMFs expected in the near future. There has been an increase in GMF registration as a result of Bill 20 and the 85 per cent patient registration target imposed by the Ministry of Health and Social Services (MSSS). Some regions have reached a 100 per cent registration rate, while others are having some difficulties.

It is estimated that 300,000 people in the province are without a physician. A new service was launched by the MSSS in fall 2017—the GAMF (Guichet d'accès à un médecin de famille). The GAMF allows patients to register for a family physician online in accordance with a priority list.[129] Pre-registration allows family physicians to add a patient from the list to their roster without the obligation of an immediate visit.

YELLOW

## 3. Team-based care

GMFs and super clinics are team-based primary care models that enlist physician services, nurses, and other health care providers, depending on community needs. On average, one GMF serves around 15,000 people and includes approximately 10 physicians, two nurses, two administrative support staff, and can include other health care providers such as pharmacists and social workers.[130] GMFs receive funding for nursing staff based on the number of patients enrolled. For example, a GMF with approximately 15,000 enrolled patients receives funding to hire two nurses (70 hours/week).[130]

Professional services are also discussed among the regional institutional leadership and GMF management, to avoid overlapping responsibilities.

GREEN

## 4. Timely access

Several GMFs have implemented advanced access to offer more options to their patients, and/or have agreements with hospital emergency departments to redistribute patients presenting at the departments for cases that are not considered emergencies.

Other measures include advanced clinical evaluations that allow patients to speak to a professional (usually a nurse) from their clinic and, depending on the situation, begin certain diagnostic procedures before their appointment with a physician. Several GMFs have increased their hours (evenings, weekends), depending on the client base served, to offer enhanced services. However, legislation has placed penalties on GMFs whose patients seek care in other settings.

Quebec also has super clinics, which are similar to GMFs but also provide consultations to patients without a family doctor or who are not registered with a GMF, and provide care seven days a week, 12 hours a day (with some exceptions).[131]

YELLOW

# Quebec

## 5. Comprehensive care

GMFs provide comprehensive services to patients, often including a family physician with certified enhanced skills—community of practices (sports, maternal, etc.).

The responsibility for public health falls more within the mandate of the Centres locaux de service communautaire (community health centres). GMFs can suggest programs, but decisions are typically made by regional institutional leadership, which ensures that responsibilities and staff do not overlap.

The MSSS has also recently recognized that physicians working with patients who are in long-term care facilities will not be penalized for failing to reach the target client registration rate (continuity of care). Going forward, this clientele will be considered a part of their patient roster.

YELLOW

## 6. Continuity of care

EMRs have played an important role in the advancement of continuous care. The Québec Health Record (QHR) is an EMR-linked tool that allows physicians and other health care professionals to access information deemed essential to providing timely and quality care to patients. Family physicians and other health care professionals have direct access to their patients' laboratory results, medical imaging, and pharmaceutical records through the EMR.

The possibility of allowing patient access to certain information included in the QHR is being discussed at the provincial level. In the GMF, it is made explicit that by registering, patients also authorize sharing information among professionals at the GMF.

Although EMRs have helped enhance continuity of care, more support is needed to ensure there is open communication between clinics and hospitals. The ongoing transfer of information allows physicians to have the most up-to-date information when meeting with patients.

YELLOW

## 7. EMRs

Most, if not all, GMFs have implemented EMRs. Incentives were offered through the Programme québécois d'adoption du dossier medical éléctronique (PQADME) to facilitate this transition. To claim incentives from the PQADME, physicians must be practising in a primary care clinic.

The EMR continues to evolve and provide more options, such as integrating pharmacists (prescriptions written through the EMR), and accessing laboratory results, medical imaging, CSST reports, and so on. Information is sharable among professionals in the same GMF.

The QHR is the provincial EMR provider. With the QHR, authorized people can see specific health information. Quebec began implementing the QHR in the summer of 2013, and it is progressively being put in effect. All residents who are registered with the Régie de l'assurance maladie du Québec (RAMQ) will have access to QHR as health care facilities and clinics become connected.

The QHR includes prescribed medications that are obtained from pharmacies that are linked to the QHR; prescriptions that are given in electronic form; results of lab analyses that were done in a public Quebec health care facility; and the results of medical imaging exams (X-rays, scans, MRIs, etc.) that were done in a public Quebec health care facility. More information will be added to the QHR in the future.[132]

YELLOW

# Quebec

## 8. Education, training, and research

Family medicine residents are trained in university family medicine groups (Groupes de médecine de famille universitaires or GMF-U).[131] The GMF-U management framework is similar to that of GMFs and they respond to the same needs. However, a QI agent (agent d'amélioration continue de la qualité) is added to the professionals working at a GMF-U; the role is financially supported by funding to the GMF-U. There are existing communities of practice for this new role, as well as roundtables with a QI managing advisor (cadre d'amélioration continue de la qualité).

GMF-Us also benefit from their proximity to research sites through their affiliation with universities and their practice-based research networks (réseau de recherche axé sur les pratique de première ligne).

GREEN

## 9. Evaluation and quality improvement

To date, GMFs have no requirement for evaluating the effectiveness and quality of their services beyond rostering and consultation rates. Some GMFs would like to use data extraction to measure effectiveness; EMRs are now required to permit data extraction, although this is in progress.

Over the last year a new professional has been added to the GMF-U structure, the QI agent. If this resource is beneficial, non-university GMFs may also wish to receive funding to add these professionals to their staff.

YELLOW

## 10. Internal and external supports

Physicians in GMFs are paid via FFS, but direct public funding is added to cover specific aspects of operating expenses such as client enrolment. There are also opportunities for physicians in the GMF to earn additional money (e.g., $10 per registered patient; a doctor running the GMF gets $350). The average cost of supplementary funding for a GMF is $275,000. GMFs also can access financial subsidies and fee adjustments—this funding envelope represents $270,000 on average for a GMF with around 15,000 enrolled patients.[131] Obtaining GMF status allows practices to receive funding for two administrative support staff (secretary and administrative technician) for 10 full-time physicians.[130]

YELLOW

# Saskatchewan

## 1. Patient-centred care

The Government of Saskatchewan released a framework in 2012 that aims to achieve a high performing primary health care system that focuses on care that is patient-centred, community designed, and team delivered.[133] In December 2017 Saskatchewan transitioned from 12 regional health authorities to a single health authority. The transition is intended to create a health system that enables health care providers to ensure that every patient, client, and resident can expect, and will receive, high-quality and timely care regardless of where they live.[134]

YELLOW

## 2. Personal family physician

One of the goals of the framework for achieving a high performing primary health care system is "Everyone in Saskatchewan—regardless of location, ethnicity, or underserved status—has an identifiable primary health care team they can access in a convenient and timely fashion."[135] One measure of success to ensure this goal is met within five years is that all regional health authorities should have a process in place for referring patients who are without a regular primary health care provider to an available primary health care team.

The Saskatchewan Health Authority provides a list of family physicians taking on new patients.[136]

YELLOW

## 3. Team-based care

The 2012 framework for achieving a high-performing primary health care system states that to achieve its goal the government will ensure funding is flexible and will encourage team-based care that meets the needs of patients, families, and the community.[133]

Collaborative emergency centres (CECs) are a model of health care delivery that improves access to stable, reliable primary health care. A primary health care team, including physicians and nurse practitioners, offers extended access hours during the day, and a registered nurse and paramedic (with physician oversight) provide urgent care assessments and treatments overnight (8:00 p.m. to 8:00 a.m.).[137] There are currently five centres that are open or in the development phase.[137]

YELLOW

## 4. Timely access

The 2012 framework for primary health care focuses on patient-centred care and timely access to care. One of the main goals is for everyone in Saskatchewan to have an identifiable primary health care team they can access in a convenient and timely fashion. The framework defines a few measures of success to be identified within a time frame, including that within two years 75 per cent of Saskatchewan residents are aware of what primary health care services are available to them.[133]

CECs were introduced to address the challenges of providing health care in rural communities. CECs are open 24/7, providing evening and weekend access to primary health care providers. They also include access to same- and next-day appointments, and shorter waits at emergency departments.

YELLOW

## 5. Comprehensive care

Saskatchewan has many physician compensation programs. The Family Physician Comprehensive Care Program recognizes family physicians for the value and continuity of care they provide to patients when they provide a full range of services. The program intends to incent more physicians to provide comprehensive care. The General Practitioner Specialist Program provides a bonus payment and mentorship to family physicians that provide anesthesia, surgery, and obstetrics services in rural and regional areas. The Chronic Disease Management Quality Improvement Program provides clinical tools to health care providers to help them follow best practices when they provide care, and collects data that give health care providers a clear and complete picture of a patient's condition and care history.[138]

YELLOW

# Saskatchewan

## 6. Continuity of care

In 2018/2019, the government invested $19 million to support the Connected Care Strategy.[139] Connected care focuses on a team approach that includes the patient and family, and extends from the community into the hospital and back again. It is about connecting teams and providing seamless care for people with multiple, ongoing health care needs, focussing on care in the community.

YELLOW

## 7. EMRs

The Saskatchewan EMR Program,[140] in partnership with the Saskatchewan Medical Association (SMA) and the Saskatchewan Ministry of Health, assists physicians with implementing EMR systems. Physicians can receive ongoing support to adopt one of two approved EMR vendors.

YELLOW

## 8. Education, training, and research

The Saskatchewan Health Research Foundation and the Saskatchewan Centre for Patient-Oriented Research will provide each research leader up to $250,000 over three years to support their work with patients and provide evidence-informed improvements for the health care system, while striving to improve patient outcomes through relevant and timely research.[141]

Under the Rural Physician Incentive Program,[142] recent Canadian and international medical graduates who establish a practice in a rural or remote community that has a population of 10,000 or less can apply for an annual basis for retention incentives (up to four years, with incentives ranging from $10,000 to $15,000 depending on the program year).

YELLOW

## 9. Evaluation and quality improvement

Compensation is available through the SMA's negotiated funds to support physicians who are interested in pursuing QI work.[141] Saskatchewan uses lean methodology for QI, which is the continuous pursuit of improvement through the elimination of waste as defined by the patient. Lean engages and empowers employees to generate and implement innovative solutions, and to fundamentally improve the patient experience on an ongoing basis. Saskatchewan is the first province in Canada to use this approach across the entire health care system. More than 1,500 continuous improvement projects have been launched in Saskatchewan's health system.[141]

The Resident Quality Improvement Program, which is delivered in partnership by the Health Quality Council and the University of Saskatchewan's College of Medicine Postgraduate Medical Education office, introduces resident physicians to the foundational elements of QI methodology and helps them see opportunities for making changes in their practices that will result in more timely and safer patient care.[143] The Physician Compensation Quality Improvement Program compensates physicians for eligible time they spend on approved QI training and projects that support provincial health system priorities as indicated on the Provincial Leadership Team approved system matrix.[144]

The Clinical Quality Improvement Program[145] is a 10-month course designed to build capability in leading improvement work in health care, with a focus on clinical QI projects. The program includes a mix of theory and experiential learning, along with individual coaching and a community of practice.

GREEN

## 10. Internal and external supports

Key investments in the 2018/2019 budget[146] include $49.4 million toward physician services (including existing services and recruiting new specialists and primary physicians) and $19 million of federal funding to support the provincial Connected Care strategy to improve access to team-based community health services and primary health care for patients who may be best served in a home or community setting.[147]

YELLOW

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THE COLLEGE OF FAMILY PHYSICIANS OF CANADA

LE COLLÈGE DES MÉDECINS DE FAMILLE DU CANADA

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