The Promise of Primary Health Care

The Community Master Plan Working Document

Preface

In February 2010, Primary Health Care and the District Department of Family Practice presented a draft operational plan for the delivery of health services in the community to Capital Health’s Leadership Executive Team. This blueprint, summarized below, has been designed based on:

• The Nova Scotia Primary Health Care Renewal Strategy;
• Several years of joint effort that started with federal funding for primary health care projects, which evolved into the Capital Gains Framework;
• The vision that emerged from the Health and Healing Promise Council from Strategic Quest;
• Initial citizen and provider discussions;
• Best and promising practices from elsewhere; and
• Alignment with Capital Health’s Our Promise’s 2013 Milestones.
Known as the Community Master Plan, we are suggesting practical steps for a restructured primary health care system in our district. In addition to alignment with the 2010-2013 Community Health Plan recommendations, there is further consultation yet to be undertaken, and feedback incorporated from a myriad of stakeholders, before the community master plan becomes a reality. We are very excited to have this draft plan in place as we move from years of talk into action, which will change the way we experience primary health care in our community.

**INTRODUCTION**

Capital Health is on a journey to become a world-leading haven for people-centred health, healing, and learning. As part of this journey, we are transforming the way that health care services are provided so that Capital Health, along with our partners, can support citizens and communities to start well, live well, and finish well.

Health care services are not only provided in a traditional hospital setting; they begin in the community. The wide range of ‘first contact’ health care services that citizens receive in their communities is referred to as the primary health care system.

Primary health care is at the centre of a community-based health care system. It focuses on a person’s health and well-being. It brings individuals, families, health providers, and community organizations together to take an active role in identifying and delivering health services in the community.

Research has shown that an effective primary health care system provides *(adapted from D. McMurchy)*:

- Supports that enable people and communities to build capacity to live well;
- Resources to enable people to build capacity and confidence to better manage chronic conditions;
- Team-based care so that people benefit from the collaboration of different types of primary health care providers;
- Access to urgent care during all hours;
- Effective and efficient information exchange between health care providers;
- Quality improvement programs to continually improve the ways in which care is provided; and
- Support for primary health care providers, including appropriate infrastructure and remuneration.

There have been many positive changes to the primary health care system in the past few years. And now it’s time to work together to build on these successes and take the next transformational step.

**WHAT SHOULD BE TRANSFORMED FIRST?**

There are many changes that can be made to strengthen and support the primary health care system over time. Incorporating what we have heard from ongoing citizen and provider engagement, we will begin the transformation with four main initiatives:

**WELLNESS PROMOTION:** Through the Community Health Teams, we will continue to focus on wellness and prevention programming as well as management of common risks that exist across chronic conditions. We recognize that each community has different needs (including under-served and vulnerable populations), and therefore may require different programs, services, and supports. Some of the components of this initiative will include:

- Personal wellness and health assessments;
- Goal setting and motivational counselling;
- Group physical activity/exercise programs;
- Group nutrition and education programs;
- Self-management peer support programs; and
- Wellness navigation to help people make linkages with the appropriate services, supports, or programs that are needed to achieve optimal health.

**CHRONIC DISEASE MANAGEMENT:** Building on the Community Health Team model, we will focus on supporting people who live with a chronic condition to effectively manage their disease. This will transpire as improved coordination between the primary health care system and the other parts of the health system, and will pay particular attention to improving care coordination for people who have more than one chronic disease. We recognize that every individual has the responsibility to manage their own health; through this initiative we will share that responsibility by making it easier to do so. Some of the components of this initiative will include:

- Opportunities for individuals to build confidence in self-management;
- A shared-care approach to chronic disease; and
- Coordination of intensive case management across programs to support individuals who struggle with managing multiple chronic conditions.

**ENHANCED TEAM APPROACH TO PRIMARY HEALTH CARE:** Currently in some Capital Health communities, citizens have access to a team of primary health care providers through health centres and family practice teams. Our goal is to continue to expand these teams.

**ALL HOURS URGENT CARE:** Citizens with urgent problems expect timely access to care in the most appropriate setting by the most appropriate provider. Ideally, those with an urgent health concern should be able to access informed and effective triage and advice by telephone or other electronic means, followed by a visit to a primary health care provider on the same day, if appropriate. Also ideally, people who are unable to travel to see a primary health care provider should be able to receive the care they need in their own home. This initiative will focus on improving access to urgent care for citizens who live in the Capital Health district, which includes HRM and West Hants.
By working in partnership with family physicians across the district, and in consultation with communities, we will support practice change to enhance same-day access and implement an all hours care system that:

- Ensures that citizens know how to access care for an urgent health problem (rather than using the emergency department as a default);
- Assists family physicians in coordinating an all hours call system that both provides coverage across the district and distributes workload fairly; and
- Provides family physicians with supports that enable all hours care to be provided safely and effectively.

We will continue to engage citizens and partners as we design and implement the above initiatives. A key feature will be structured opportunities for the people who use the system to participate in the discussions and decisions that affect them. The process to develop this transformation plan for primary health care began with community conversations, and we are committed to working with our community health board members and coordinators to continue to find ways of actively engaging residents of the district in the transformation process.

**What are some of the Key Changes we can Expect to See?**

### Primary Health Care Zones

To organize primary health care services in Capital, we are recommending that the district should be divided into primary health care zones (PHC zones). In consultation with citizens and health partners, zones will be determined based on the patterns of service-use within natural communities, and will be informed by other considerations such as population density (proposing zone size should be < 50,000 people), existing family physician call groups, Community Health Board boundaries, public health, mental health, addictions, and continuing care service areas. PHC zones will be a point of planning and integration for all aspects of community based health care, including local community agencies and services not always considered part of the health system. Further discussion is required with the Community Health Boards as PHC zones and CHB boundaries may be one and the same.

It is envisioned that within each zone, people will have access to their family physician and a team of primary health care providers and community partners who will work together to provide coordinated access to health care services. This system of zone membership would enable primary health care teams to better identify the health needs of the particular populations. It would also help primary health care teams to provide better continuity of care. It is our intention that residents will benefit by having access to a regular and trusted team of providers as their entry point into comprehensive and person-centred primary health care.

In general, the draft design of this plan suggests that people will be members of a zone based on where they live, much like how families with children send their children to the school that lies within their geographic school district. If an individual already has a primary health care family physician that practices outside of the geographic zone in which they live, they will be assigned membership to the zone where they are currently seeking their primary health care. Even though this new organizational structure planning is based on geographical boundaries based on residence, citizens currently seeking health care outside of their residential-based zone should not experience barriers to care. Generally, individuals will be referred to health care resources in the zone where their primary health care provider is located and where they have registered; however, it is also proposed that cross-zone referrals will be possible as appropriate.

It is expected that each PHC zone within Capital Health will establish formalized agreements to better support family physicians and other primary care providers to improve access, clinical care, communication, collaboration, and health outcomes within a geographic area. Family physicians will be encouraged to form real or virtual family physician groups, practicing either in the same office setting or in different locations, but linked with one another through electronic information and communications technology to facilitate transfer of information and to share clinical responsibilities.

Within each PHC zone there will be a coordinated zone-wide all-hours urgent care network to ensure that citizens have access to urgent care from the most appropriate primary health care provider 24 hours a day, 7 days a week. In addition, each PHC zone will:

- Facilitate access to the Capital Health Electronic Health Record;
- Coordinate inter-professional care networks that will provide wellness and chronic disease prevention and management programming for specific sub-populations and communities of need;
- Establish linkages with and help improve access to secondary care (secondary care is the type of care provided when a family physician refers their patient to other health care providers, who usually are not the first point of contact for patients, such as medical specialists like cardiologists or surgeons);
- Coordinate the provision of lab and diagnostic services as needed to support primary health care; and
- Provide coordinated interdisciplinary services for people with chronic diseases based on the chronic care model, at a location ‘close to home.’
Making a Difference

As part of Our Promise, Capital Health has identified a number of key milestones that we plan to achieve by 2013. We will not be able to achieve these milestones without transforming the primary health care system. Doing things differently by investing resources and change efforts in the ‘first contact’ of the health care system will not only improve the person-centred health care experience; it will contribute to a more sustainable health care system.

Once primary health care begins to be organized into agreed upon zones after further consultation with communities, it is foreseeable that the PHC zones can be an enabler to organize aspects of secondary care in a similar manner. For example, some secondary care services can be moved out of the traditional hospital setting and located closer to the communities to be served, offering periodic access to secondary care services within each zone.

Zone Advisory Committees

No one knows more about community health priorities than the people who live and work in their respective community. For this reason, every proposed PHC zone will have an Advisory Committee to guide the activities of the zone, with membership reflecting the citizens and primary health care providers from the particular communities, as well as representatives from Capital Health.

Zone Advisory Committees will be developed and informed by the Community Health Boards. They will use available health information to identify primary health care service priorities for the zone and to monitor the outcomes of initiatives.

Enhanced Team Approach to Primary Health Care

As part of the Community Master Plan, we want to expand opportunities for citizens to access primary health care teams, which contain different types of health providers. Building on past experience, Capital Health will phase in a Family Practice Nurse Program within each zone to provide primary care physicians in family practice groups with the option to work collaboratively with family practice nurses. Family practice nurses can practice to their full scope, offering services such as Well Baby, Well Women, and Well Men’s clinics, chronic disease management, immunizations, and medication adjustments.

According to the unique needs of their specific patient population, some family practice groups may collaborate with other health care professionals, such as nutrition counsellors, respiratory therapists, physiotherapists, occupational therapists, public health nurses, addictions counsellors, mental health specialists, and others. Similar to the Family Practice Nurse Program, and in consultation with health providers, we plan to phase-in an inter-professional care network within each zone to provide primary health care physicians in family practice groups with the option to work collaboratively with a range of providers, either on site or conveniently located within the zone, each practicing to their full scope.

Community Health Teams will expand to specific communities within the zones to support wellness and prevention programming that meets the unique needs of specific populations. Community Health Teams will focus on health and wellness and collaboratively work with other provider groups and community-based services to support integration of services in the community.

Continuous Learning and Quality Improvement

Experience elsewhere tells us that an effective way for primary health care providers to continue to learn and support improvement in health outcomes for their clients and patients is through a collaborative approach. Collaboratives are groups of health care providers who identify a clinical health issue and then work together to learn and share ways of improving the clinical outcomes related to this issue. As part of the transformation of the primary health care system, Capital Health will support the development of collaboratives within and across PHC zones. We are recommending that the first collaborative should focus on a condition that is difficult for individuals to manage and that results in frequent emergency room or hospital usage (such as congestive heart failure, diabetes, and/or anxiety). We also plan to provide support for measuring clinical outcomes within and across zones, so we can see the impacts of our primary health care system transformation.

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This draft plan is based on what we have heard from our citizens, providers, and funders. After further discussion and consultation we expect to incorporate changes, which will ensure a successful implementation of this Community Master Plan; in essence, moving talk to action. We want to share our blueprint with you so that we may further the dialogue and receive feedback on how components of the plan may work, or what may work better from your perspective. If you have read this and would like to speak with us or would like to share your thoughts in writing, please contact us:

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