PRIMARY CARE ROAD MAP

Prince Edward Island
CANADA

Modernizing Primary Care on Prince Edward Island

2021

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Executive summary

Primary care is an essential initial and ongoing point of contact with the health system for community members to maintain health and wellness. The Primary Care Road Map provides a two-year path forward to achieve continued progress in ensuring the provision of quality, equitable and patient focused primary care services on Prince Edward Island (PEI). The plan focuses on four priority areas:

- access to care
- team based care
- innovation and virtual care
- integration and coordination

Within these four priority areas are example actions that align with the internationally recognized Quadruple Aim Framework for health. This framework fosters ongoing engagement with Islanders, better population health outcomes, improved patient experience and improved healthcare provider experiences, and lower cost of care. This strategic direction is intended to enable Islanders to maintain a "patient's medical home" where they can access care from a team focused on collaborating to provide patient centred care. Based on the College of Family Physicians of Canada "Patient's Medical Home" (2019) concept, Prince Edward Island's patient's medical home approach will emphasize the provision of accessible, continuity of care through the life cycle which is provided in collaboration with other health, social and community services.

The plan will be operationalized beginning in 2021 and set the stage for the development of a five-year primary care strategy.

Background

Primary care is an essential initial and ongoing point of contact with the health system for community members to maintain health and wellness. Offered by a range of health care providers, primary care providers direct services such as diagnosis, screening, acute and ongoing treatment, education, and disease prevention and management. Primary care providers also coordinate referrals and contacts with other health and community service providers to enable effective comprehensive patient care. On Prince Edward Island primary care includes physician offices and health care centres located in five primary care networks distributed across the province.

Primary care services on Prince Edward Island have experienced challenges as well as achieved progress in advancing patient care. In recent years, a number of initiatives to enhance primary care have been introduced including Primary Care Networks, the addition of nurse practitioners, adoption of a primary care case management program, and chronic disease prevention and management programs. Progress is also being achieved with the development of a provincial electronic medical record, a rural health initiative and a virtual health strategy. These developments have proceeded within the context of increasing challenges in accessing primary care, increasing wait times, lack of continuity of care, physician retirements and provider burnout.

As primary care services respond to current and emerging population health challenges, continued work is required to transform services to respond to these challenges and ensure their sustainability. Government provided approval to proceed to develop a five-year primary care strategy for Prince Edward Island prior to Covid-19. Planning for primary care needs to occur in the context of providing care during the pandemic, taking action on immediate and short-term priorities while developing a longer term strategy. The two-year primary care road map is the next immediate step to define a course for action on priority issues while the five-year primary care strategy is being developed.

Developing the Road map

A Steering Committee composed of members from the Department of Health and Wellness, Health PEI, Medical Society of Prince Edward Island, Prince Edward Island College of Family Physicians, and the Department of Social Development and Housing was established to work collaboratively to:

- Identify priority areas for action and advise on the implementation sequence of next steps to advance primary care
- Guide stakeholder engagement activities during the development of the road map
- Develop a governance model, evaluation and accountability framework

In recognition of the essential role of teams in advancing primary care, a Team-based Care Working Group, comprised of primary care providers and patient representation, was commissioned to develop a team-based care guidance document. The development of this document was informed by the results of stakeholder engagement, a jurisdictional scan of primary care services, a review of scientific papers, grey literature, primary care support resources/toolkits for best practices, and identification of illustrative examples of team-based primary care on Prince Edward Island.

Engaging Stakeholders

As part of the development of the road map a number of engagement activities (surveys, focus groups and key informant interviews) were held with key stakeholders, including health system staff, community and government departments and patients with and without a primary care provider. The engagement activities were designed to solicit information on four dimensions of primary care (access to care, team based care, virtual care, and transitions to community based health services) specifically what was working well, areas for improvement and to garner new ideas. The results from the engagement activities were collated and used to inform the development of the road map.

Aims

The two-year primary care road map provides a path forward to achieve continued progress in ensuring the provision of quality, equitable and patient focused primary care services on Prince Edward Island.

The road map confirms the integral role of collaborative team-based practices, where health, social and community providers use a community health approach to strengthen the integration of services and work towards innovative solutions to improve the health of Islanders.

The road map sets the stage for the development of a longer term five-year strategy for primary care.

Responding to Challenges

Primary care services on Prince Edward Island are essential in addressing important population health challenges including:

- Higher incidence of risk factors for chronic disease (physical inactivity, obesity, low fruit and vegetable consumption, heavy drinking rates) compared to the rest of Canada
- Significant health burden caused by chronic diseases (cancer, cardiovascular disease, chronic pulmonary disease, and diabetes) which account for at least 70% of population mortality, illness and disability
- Requirement for programs and services to support healthy aging in a population where one in five residents is over 65 years of age
- Challenges accessing primary care, mental health and addictions and home care within communities and as a consequence Islanders may experience longer lengths of stay in acute care, limited opportunities to manage chronic conditions, and more frequent visits to emergency departments
- Similar to other provinces and territories, the recruitment and retention of health care providers to sustain the workforce in anticipation of increased population size, retirements and ensure capacity to implement new initiatives is challenging
- Uneven distribution of the social determinants of health (e.g. income, education, employment) among the population to the degree that Islanders with the lowest household incomes face greater health risk factors and worse health outcomes.

The emergence of the COVID-19 pandemic has also created new challenges for primary care services and intensified the need to accelerate action. These challenges have included:

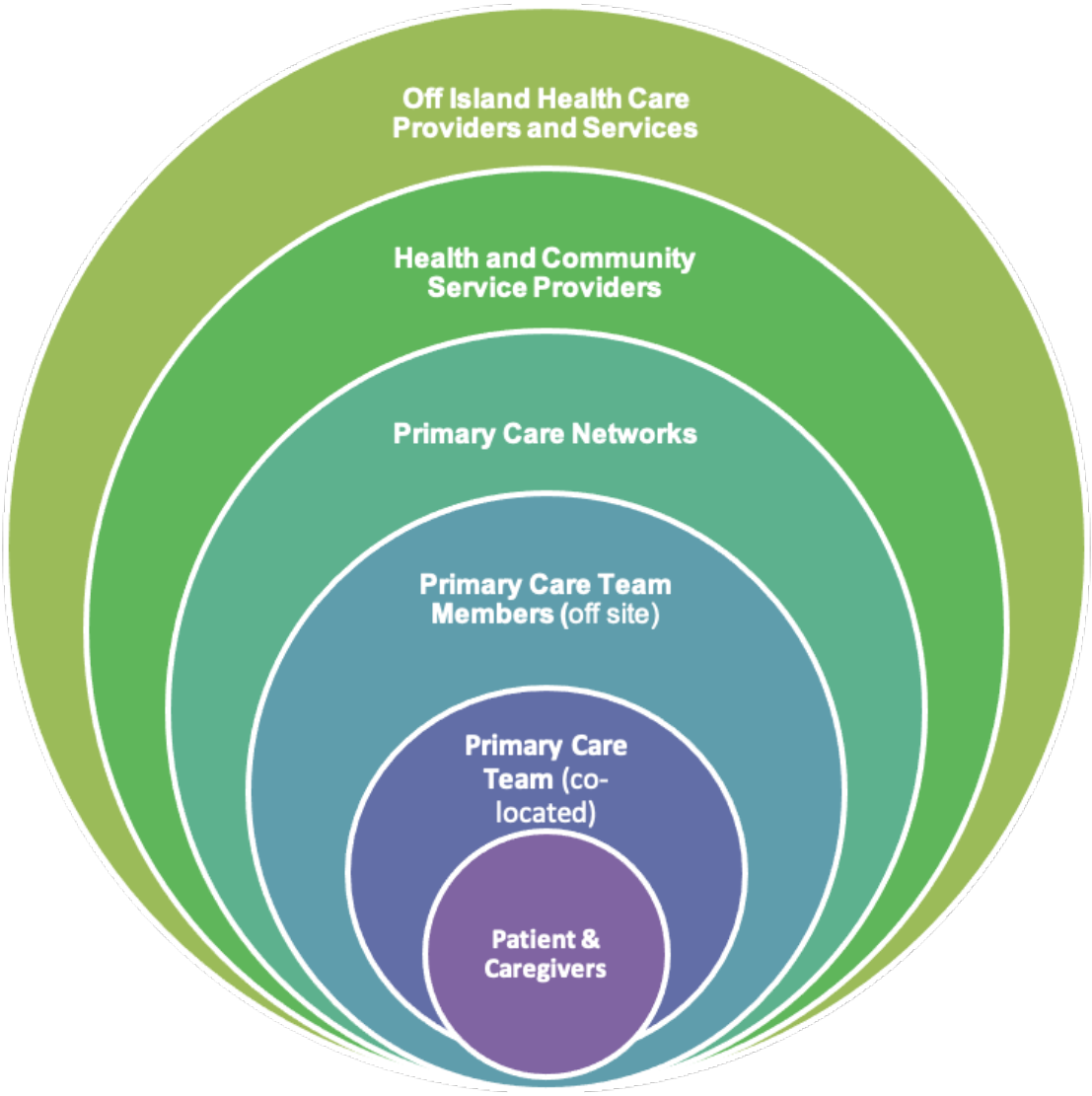
- Disruption of services as primary care clinics significantly limited in-person appointments
- Reduction of screening and most chronic disease management programs
- Many primary care staff were redeployed to COVID clinics

The uncertainty created by the pandemic and the requirement to maintain vigilance while balancing competing demands is a challenge for health care providers, planners and decision makers. Primary care services have adapted to the health and safety requirements necessitated by the pandemic however long term planning for these services must continue to ensure their sustainability.

Building on Opportunities and Assets

In the process of planning for primary care services the assets and opportunities which can be leveraged should also be recognized. Some of these include:

- A highly skilled workforce of dedicated primary care providers
- Potential synergistic linkages between primary care services and other population strategies and initiatives such as the mental health and addictions strategy, virtual health care planning, rural health initiative, and seniors health services plan
- Expedited adoption of virtual health care solutions as a consequence of COVID-19 which shifted care to telephone or video appointments when appropriate. Primary care services can continue to implement digital care to meet patient needs closer to home
- Government endorsement of a collaborative team-based approach to primary care.



Working Together to Provide Primary Care

Guiding Principles

Primary care services will reflect the following principles:

Improving patient experience and supporting families. As patients and their caregivers/care partners interact with primary care services they experience respect, exercise choice, and are active participants on the primary care team.

Enhancing community wellbeing. Primary care teams address the needs of the local community by assessing these needs and offering health promotion, disease prevention, screening, education and treatment services. The composition of primary care teams may vary, depending on the requirements of the local community.

Supporting wellness and improved experience of health care providers. Primary care services are predicated upon maintaining healthy worklife conditions for health care providers. In their daily work primary care providers experience respect, have opportunities to contribute to a healthy working environment and have access to supports and services to enable the maintenance of their personal wellness and job satisfaction.

Improving access – right provider, place, time and service. Team based primary care enables health care providers to collaborate to contribute their full knowledge, skills and experience to patient care. Timely access to the primary care provider with the right skill set to most effectively address the patient's health needs is a cornerstone of care.

Facilitating coordination, integration and collaboration. Primary care teams are assembled according to the patient's care needs. This approach requires effective working relationships and communication between primary care and other health, social and community services.

Leveraging technology. Primary care services use available technology to provide safe, quality care and seek opportunities to test emerging innovations in service delivery.

Quality care and using evidence. Research and clinical practice guidelines form the basis of quality primary care service delivery. As learning organizations, primary care services are committed to quality improvement.

Accountability. As part of a team, primary care providers are accountable to other team members and strive to improve provider experience in the workplace. Primary care services are also responsible for delivering value for public funds invested.

Ensuring sustainability. Primary care is planned and delivered in ways that improve the health and wellness of patients and health care providers. Providers monitor the results of the care provided and change services, as required, to ensure value.

Quadruple Aim Framework

The internationally recognized Quadruple Aim framework provides an evidenced based model with which to guide decisions and ensure that primary health care delivery achieves results that positively impact: population health, patient experience, cost of care, and provider experience. The Quadruple Aim framework was used as a guiding framework during the development of the road map.

The updated version of the Institute for Healthcare Improvement (2007) Triple Aim framework for improving health care, the Quadruple Aim addresses the goals of modernized primary care services. The framework retains the overall goal of better population health outcomes achieved by providing flexible, comprehensive primary care services that improve patient experience, improve healthcare provider experiences at a lower cost of care (achieved through focusing on increased efficiencies and cost avoidance), matching the patient with the right provider, at the right time and in the right place.

Priorities and Supporting Initiatives

There are four priority areas for action in primary care over the next two years; access to care, team based care, innovation and virtual care and integration and coordination. Within these four priority areas there are initiatives that can support progress on the four priorities while fostering:

- Ongoing engagement with Islanders
- Improved patient experience
- Improved healthcare provider experiences in the workplace
- Shared accountability

Priority area for action: Access to care

Many Islanders do not have a primary care provider or have variable wait times for an appointment with their provider; planning is also needed for transitions into team based care and pending physician retirements.

Key objectives

- To improve and stabilize access to primary care, with a particular focus for unaffiliated and vulnerable patients, and to proactively transition to team based care.

Initiatives supporting key objectives

Improving access to primary care requires a strong foundation of primary care providers. This foundation can be built and maintained through inventorying the services and providers within current primary care networks, recruiting providers to fill human resource gaps and reviewing locum policies to ensure that teams have sufficient providers available to fulfill requirements.

Two groups of patients, those transitioning from acute care and those who do not currently have a primary care provider, can benefit from new initiatives that increase access to care. For example, transitional services that offer virtual and in-person primary care may help to facilitate early and timely discharge from hospital and prevent readmission for those who do not have a primary care provider. Updating the process of assigning primary care providers may be of particular benefit to people on the patient registry with high risk health conditions.

Individuals who currently have a primary care provider can also benefit from initiatives that increase access to primary care. For example, the development and implementation of after hour primary care services and 'primary care provider of the day' clinics may help to provide more timely care and reduce emergency department visits.

Reference: College of Family Physicians of Canada. A new vision for Canada: Family Practice —The Patient's Medical Home 2019. Mississauga, ON: College of Family Physicians of Canada; 2019.

Priority area for action: Team-based care

Team-based care occurs when a number of health providers with different professional backgrounds work together with clients, families, caregivers and communities to deliver care in a coordinated and integrated fashion; the right care provided at the right time by the right provider. Patients can access team-based care through "patient's medical home" where they develop relationships with a primary care team to receive continuity of care through their life stages.

Through its research, the team-based care working group identified six critical elements for effective primary care teams: defining goals and objectives, establishing high functional systems (clinical and administrative), clarifying roles and responsibilities, leadership, creating consistent high qualilty training, and instituting effective communication strategies and protocols.

Key objectives

- To grow highly effective and efficiently functioning teams
- To ensure equitable access to allied health care providers teams and Islanders regardless of geographic location

Initiatives supporting key objectives

As noted by the team based care working group, primary care teams are built and maintained through attention to providers' work life experiences and their physical environments. Developing and maintaining teams begins initially with initiatives that offer consistent on-boarding, orientation and training of new team members. A positive work life experience can continue through initiatives that promote psychologically safe and healthy workplaces, development, and employee engagement. Access to local clinical and administrative leadership is important to reinforce and support effective and efficient team based care. New and mature primary care teams may also benefit from the guidance, training, and coaching offered by a specialist in developing and maintaining teams.

The physical environment where primary care is delivered can by intentionally designed through accountable and transparent overhead (rent and support services) agreements to support team based care.

Priority area for action: Virtual care

A number of virtual care solutions have been introduced allowing Islanders to access services from their own homes and communities. Current projects have included platforms to provide service to both affiliated and unaffiliated patients to enhance telehealth and remote patient monitoring.

Engagement results underscores the need for enhanced patient, caregiver and staff help to maximize access to and utilization of virtual care solutions including equipment. As Prince Edward Island moves forward in developing a 3-year action plan for virtual care it will be important to continue to identify and adopt the best solutions to provide primary care.

Key objectives

- To leverage innovation through accelerated adoption of virtual care solutions to enhance access, team based care, integration and collaboration amongst health care providers

Initiatives supporting key objectives

The emergence of the COVID-19 pandemic has necessitated and expedited the implementation of virtual health solutions by primary care providers and patients. It is anticipated that virtual health solutions will continue, post pandemic, to be preferred by many patients because of the reduced burden of travel and increased access to specialist and other health care providers offered by this type of care. Enhanced access to care for individuals without a primary care provider may be achieved through virtual care clinics initiatives.

Progress in virtual care may be achieved along three timelines: current use, next steps and future innovation. Optimizing the current use of virtual care on Prince Edward Island will require initiatives to ensure the availability of required hardware, software, internet access, confidential spaces for virtual care in communities, and attention to the training needs of primary care providers and patients.

The next steps in virtual care solutions may involve initiatives for accessible chronic disease prevention and management to support Islanders who are managing one or more chronic conditions such as asthma, diabetes, heart disease, and chronic obstructive pulmonary disease. These initiatives may involve developing strategies to increase patient access to their health information, programming and support. The implementation of provincial electronic health records will support primary care teams to collaborate across settings and providers and may build a foundation to test on-line appointment booking for primary care services.

Future innovation in virtual healthcare for rural and urban communities will be driven by identifying and testing new ideas. On Prince Edward Island future projects, which support and align with the Virtual Care Action Plan, may be identified in collaboration with communities, patients, healthcare providers and other stakeholders.

Priority area for action: Enhanced and integrated community-based health services

There is a need for greater support when patients transition between different levels of care and programs. Survey results from the engagement process revealed that Mobile Integrated Health Programs were examples of initiatives that had enhanced the integration of care between acute care and primary care based services. To continue to advance primary care services will require additional initiatives that improve patient transitions and effective information sharing across services.

Key objectives

- To leverage all available services in the primary care neighborhood of a patient's medical home to create the conditions for optimal health care.
- To create, effective, safe and seamless transitions of care for patients as they move from service to service.

Reference: College of Family Physicians of Canada. A new vision for Canada: Family Practice—The Patient's Medical Home 2019. Mississauga, ON: College of Family Physicians of Canada; 2019.

Initiatives supporting key objectives

Effective primary care utilizes the full resources of the primary care team in collaboration and coordination with other health care providers, social and community service providers. These resources are accessed by patients within "patient's medical home" where individuals receive on-going care throughout their life stages by a team of primary care providers who coordinate care in collaboration with other health, social and community services. Progress in integrating health services can occur at the community level, between primary care teams, and between primary care teams and other healthcare providers.

Initiatives to identify local assets (providers, programs and services) that can be leveraged to provide care increases community engagement and awareness of existing services. Similarly, identifying new ways to integrate and share resources between primary care teams can create "primary care neighborhoods" which share expertise, resources and enhance the sustainability of primary care services. The introduction of mobile services can also help to reduce transportation barriers and increase access to primary care services. Shared care and collaborative case management between primary care teams and other community based services, including but not limited to mental health and addictions and/or home care, are examples of models that could be applied to enhance the effectiveness of primary care for medically complex patients.

Governance, Accountability and Evaluation

Governance and Accountability

The Department of Health and Wellness, Health PEI, and community partners will work together to achieve progress on the road map through their unique roles. Specifically, an Implementation Steering Committee will take a lead role in monitoring and reporting on the implementation of the road map, guiding progress and providing strategic advice to overcome barriers to progress. Health PEI will provide operational leadership and expertise during the implementation of road map activities.

Evaluation: Measures of Success

To provide robust measures of progress along the Primary Care Road Map targets for each of the four priority areas are proposed. The feasibility of the measurements and targets will be tested over the next two years and the lessons learned will inform the development of an evaluation framework for the longer-term primary care strategy. The Evaluation Working Group will finalize the measures of progress which may include some of the examples which follow:

Example Measures of Success

Access to care

- Same day access with primary care team to book an appointment, renew a prescriptions and acquire information.
- Extended hours of access to include evenings and weekends
- Partial open access for same day or week appointment.
- All high risk or vulnerable patients or those complex chronic conditions assigned to a primary care team.
- Increase in the number of Islanders attached to a primary care team
- 80% of Islanders rate their primary care experience as very good or excellent

Team-based care

- Number of new primary care teams.
- Healthcare providers rate work places as being psychologically safe.

Virtual care

- Number of patients on the patient registry offered and enrolling in a virtual care clinic for unaffiliated patients
- Change in primary care provider access to necessary technology and training to offer virtual care.
- Change in patient access to virtual care.

Enhanced and integrated community-based health services

- Activation of shared care model between primary care and mental health
- Outcomes of shared care model between primary care and community providers
- Collaborative case management with Social Development and Housing

Other Enabling Strategies

The Primary Care Road map connects with other strategies to enable progress in primary care, identify areas to complement, support, and build upon other initiatives while ensuring that work aligns. These strategies include, but are not limited to the following:

- *Mental Health and Addiction Strategy 2016-2026*
- *Seniors Health Services Plan*
- *Rural Health Initiative*
- *Virtual Care Action Plan*
- *Innovation Centre of Excellence*
- *Recruitment and Retention*
- *Physician Resource Plan*
- *Centre for Mental Wellbeing*

Sharing lessons learned, exploring innovative ideas, and developing projects and programs together will advance both primary care services and other important health strategic directions.

preview the strategy development.

Making it Happen

The road map presents an ambitious program of development and change for primary care services on Prince Edward Island. To ensure successful implementation the road map requires the support of communities, patients and families, primary care providers, administrators and health system leaders in Health PEI, the Department of Health and Wellness and other government departments. This support involves resources (financial, human) but also relies on regular communication and reporting on the progress of the plan to enable decision makers and leaders to provide guidance. This work will be led by a Primary Care Road Map Implementation Steering Committee.

As the road map is implemented, beginning in 2021, the lessons learned will set the stage for the development of a five-year primary care strategy. The outcomes and progress on the road map will be used by a Strategy Development Committee to guide the development of the next phase in planning.

Primary Care Road Map

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