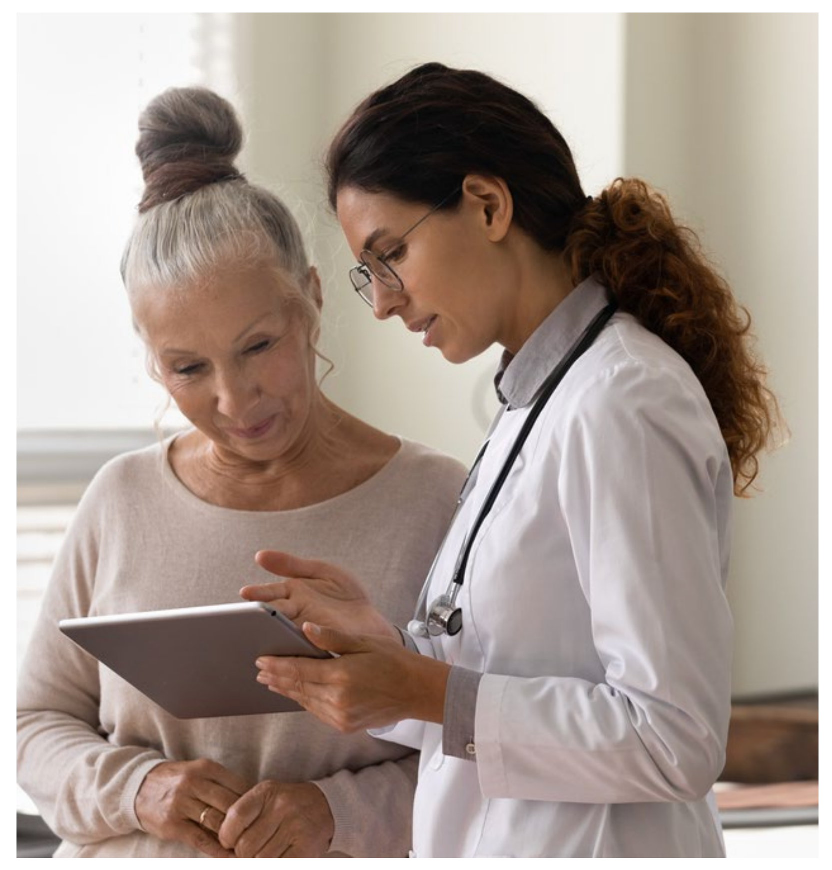


QI Power Hour

THE PATIENT’S MEDICAL HOME

With Dr. Ruddy

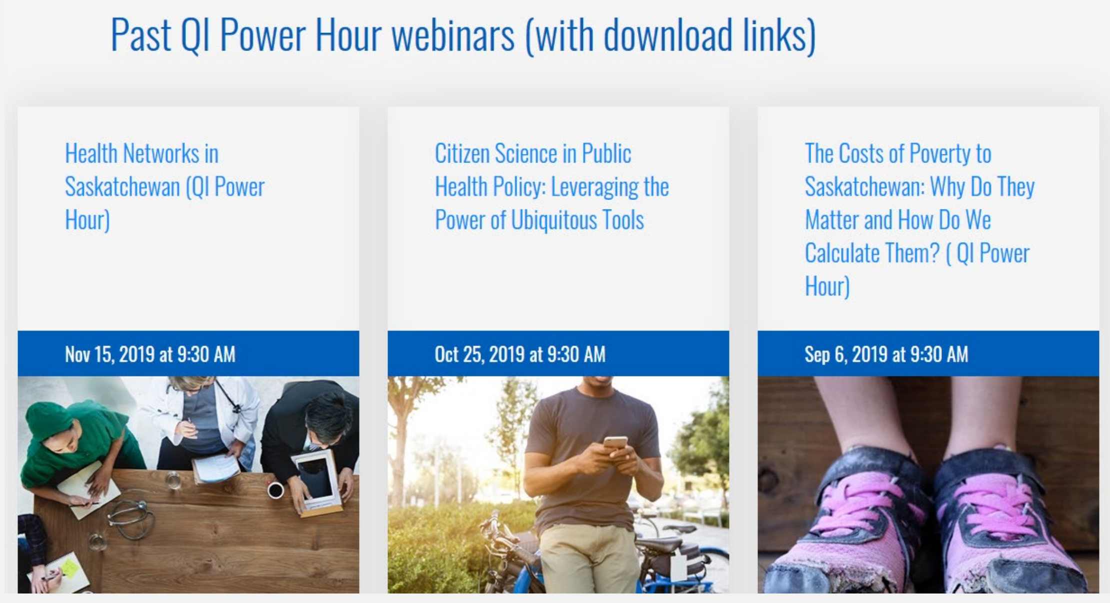
TREATY 6 TERRITORY & HOMELAND OF THE METIS

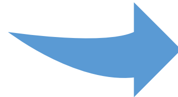
HQC is situated on Treaty 6 Territory and the Homeland of the Métis.

We pay respect to the treaties that were made on this land and acknowledge the harms and mistakes of the past. We are committed to move forward in partnership with Indigenous Nations in the spirit of reconciliation and collaboration.

Connect to Audio using Audio Broadcast

Access past QI Power Hour sessions





[Visit our website to view past sessions!]

Sign up for the QI Power Hour email newsletter

Receive notices about upcoming sessions and details on how to register straight to your in your inbox.

Visit: bit.ly/hqc_subscribe

QI Power Hour Across Saskatchewan

Over
60
Companies & Organizations

QI Power Hour Across Canada

Over

80

Companies & Organizations

QI Power Hour Across the World

Over
20
Companies & Organizations

Health Quality & Safety Commission New Zealand
Kupu Taurangi Hauora o Aotearoa

Healthcare Improvement Scotland

Milbank Memorial Fu

Air Liquid

Royal Co
of Physici

NHS

Washington State Department of Health

NHS Somerset
NHS Foundation Trust

SANOFI

Perelman School of Medicine
University of Pennsylvania

Institute for Healthcare Improvement

The Health Foundation

University of Otago
Te Whare Wānanga o Otāgo
New Zealand

Department of Corrections
Ara Poutama Aotearoa

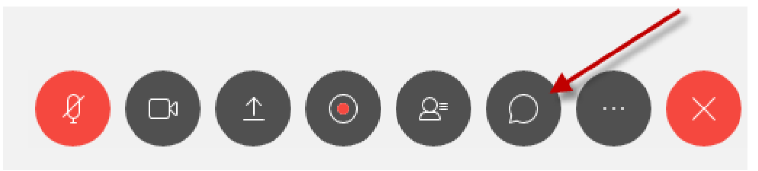
The University of Queensland
Australia

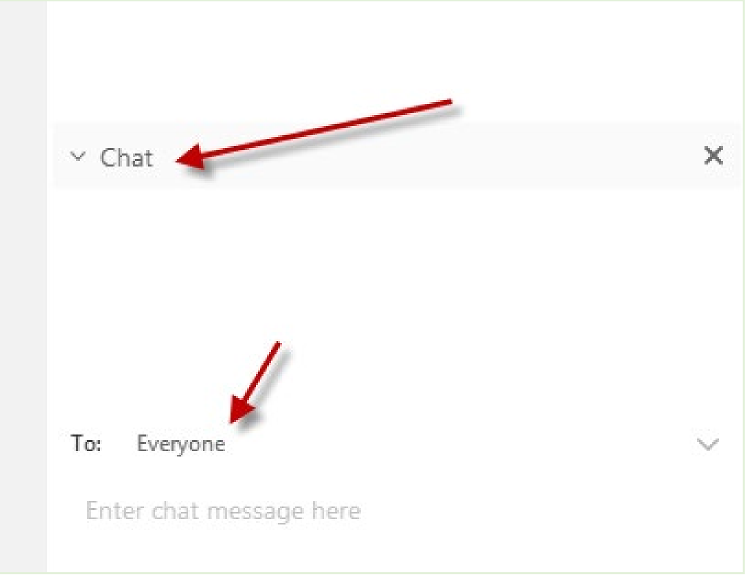
kidpower®

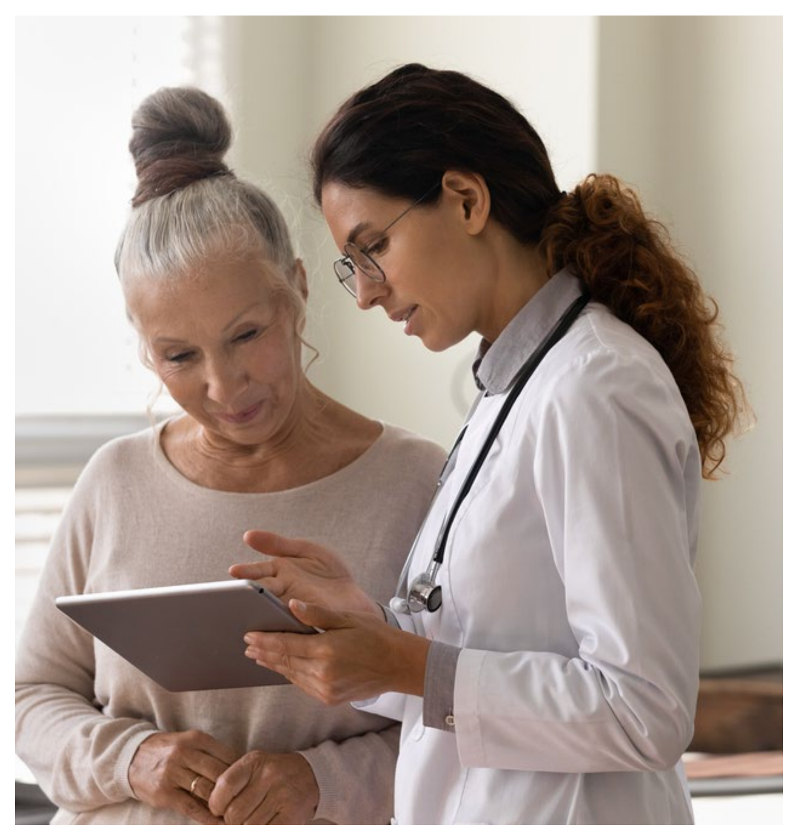
Webex tool: chat function

Chat functions:

- Share **questions**, **comments**, and **ideas**
- Click on the message bubble icon to access the chat
- Send to **Everyone**







QI Power Hour

THE PATIENT'S MEDICAL HOME

With DR. RUDDY

Building the health care we want and need

Ginger Ruddy, MD, MPH, CCFP
Assistant Dean, Office of Student Services,
UGME, College of Medicine, USask
16 June, 2023
HQC QI Power Hour

PATIENT'S MEDICAL HOME

What allows PMH to grow and evolve in response to patient and community needs.

What patients/ communities experience when PMH is implemented.

What we need from Ministry and SHA for PMH to work.

PATIENT'S MEDICAL NEIGHBOURHOOD

PATIENT'S MEDICAL HOME

- Long Term Care and Home Care Services
- Social and Community Supports
- Pharmacy
- Other Health Care Providers
- Mental Health and Addiction Services
- Other Medical Specialists
- Hospital Care
- Lab and Diagnostic Services

We are not.

Patients report that **Canadian doctors are not as supported** as those in other developed nations:

- **Limited Teams.** Only **22%** of Canadians identified a nurse or other clinic staff person regularly involved in their health care.
- **Limited Infrastructure and Funding.** Only **4%** could email their clinic with a medical question.
- **Limited Connected Care.** **1 in 5** MRPs hadn’t heard from specialists when patients returned to primary care.

General Practitioners/Family Physicians per 100,000 Population by Province/Territory, 1986-2015

Year	Canada	NL	PEI	NS	NB	QC	ON	MB	SK	AB	BC	YT	NWT	NU
1986	90	100	82	96	68	90	89	88	87	81	100	103	66	
1987	93	102	86	100	71	95	92	89	91	87	102	104	67	
1988	96	109	90	105	73	97	96	85	95	92	106	112	62	
1989	99	114	84	109	77	98	100	92	95	92	108	120	68	
1990	98	107	77	106	79	98	99	92	94	90	107	117	64	
1991	99	102	80	107	80	99	99	96	94	92	109	116	102	
1992	100	97	80	105	81	101	99	93	93	93	110	113	126	
1993	102	111	80	113	84	103	100	93	94	95	113	120	121	
1994	98	111	78	103	85	103	95	89	94	92	108	122	121	
1995	97	107	74	100	88	104	93	89	92	89	106	124	115	
1996	95	102	73	99	88	104	89	87	86	86	106	126	118	
1997	94	104	70	99	87	104	87	88	85	83	105	136	126	
1998	94	104	74	102	90	105	86	89	88	86	107	127	116	
1999	94	105	75	102	91	106	85	91	93	88	106	115	86	37
2000	94	109	77	102	91	106	85	92	93	86	107	116	71	22
2001	95	115	84	103	93	106	85	94	95	87	109	166	58	25
2002	96	113	87	108	93	106	84	93	97	96	111	158	71	35
2003	96	119	88	111	99	104	85	92	95	98	112	163	67	34
2004	97	99	95	115	101	108	86	92	87	98	109	173	85	23
2005	98	99	89	117	103	109	85	93	89	100	112	178	69	43
2006	98	103	92	120	106	110	84	92	90	103	111	195	81	32
2007	98	107	99	116	99	111	85	91	92	106	109	195	83	25
2008	101	115	101	119	107	113	85	95	93	111	112	204	76	31
2009	103	117	89	116	109	110	90	95	93	113	117	188	69	31
2010	103	118	88	114	109	111	92	98	95	109	118	178	55	30
2011	106	119	98	122	113	113	96	106	100	110	119	165	64	32
2012	109	123	99	128	117	115	100	104	99	110	124	154	60	26
2013	111	126	106	133	122	116	103	107	103	113	123	156	73	28
2014	114	129	99	131	124	118	107	105	106	118	125	169	78	30
2015	115	126	100	131	121	117	109	106	109	123	124	183	68	24

Table 1
Percentage of Canadians without a regular health care provider, by province, 2015 compared to 2019

	2015	2019
	percent (%)	
Canada	16.8	14.5 *
Newfoundland and Labrador	11.9	12.5
Prince Edward Island	11.3	14.9
Nova Scotia	11.3	14.4 *
New Brunswick	9.2	10.2
Quebec	27.8	21.5 *
Ontario	10.4	9.4
Manitoba	18.2	15.8
Saskatchewan	19.1	17.2
Alberta	19.5	14.9 *
British Columbia	16.2	17.7

* Significantly different compared to the rate from 2015 (p-value less than 0.05)

Source: Canadian Community Health Survey, 2015 & 2019.

Family Medicine is the foundation of our care:

A one-day snapshot of the most common physician services provided daily in Alberta

- MRI/CT exams 2,036
- Emergency/Urgent Care/Advanced Ambulatory visits 6,613
- Community X-rays and ultrasounds 15,269
- Minor surgical procedures 15,245
- Major surgical procedures 2,975
- Non-Family Medicine specialist community, ambulatory and inpatient visits 35,742
- Family Medicine community, ambulatory and inpatient visits 80,057

Alberta is making sure people know what family medicine does for the community

And Alberta answers: what have you done for me lately?

What Programs & Services do PCNs Offer?

Workshops

Workshops are designed to meet the unique needs of your community and are available to help patients better manage their physical and mental health.

After Hours

Many PCNs offer out-of-hours or same-day care or support to patients who can't get in to see their doctor.

Health Teams

Teams of health professionals such as nurses, mental health therapists, dietitians and social workers support family doctors to ensure patients receive the care they need.

Access

Networks of doctors, health professionals and specialists work together to reduce wait times, cut system costs and improve access to care.

Family Medicine – 628.2 FTE's

Replacement Needs by 2022/23:

590.3 FTE's

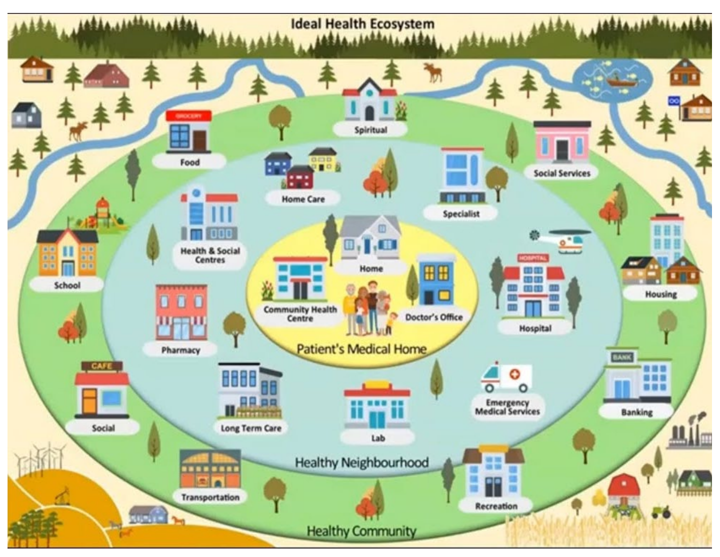
*Replacement needs are new recruits required to replace retiring or departing physicians

Growth by 2022/23:

37.9 FTE's

* Growth relates to increased needs for physician services (population growth, disease trends)

saskdocs.ca



Health Networks in Saskatchewan were created **to enhance team-based primary care. With family physician leadership**, they are an opportunity to improve care in the community and patient outcomes.

CFPC guidance to evaluate health networks.

- **Remuneration**: APPs offer flexibility and encourage innovation in organization and collaboration
- **Interoperability:** health information systems
- **Effective Referrals**: standardized, pooled, electronic
- **Evaluation** of health outcomes
- **Reporting**
- **Improvement**

SK Health Plan 2023-24

Goal I. Stronger Health Care System

i. **Improved team-based care** in the community
- **NEW Interdisciplinary teams** for continuity, quality, transitions
- **Optimize promotion, prevention and protection**
- Stabilize services for **rural and remote communities**

Success: functioning physician-led teams in clinics

ii. **Improve team-based care** in hospitals
- Shorter surgery wait times
- Greater hospital capacity with better flow-through

Success: functioning teams to care for complex patients after and instead of hospitalization

iii. Ensure adequate **Health Human Resources**

Success: all team members fully deployed at top of scope

iv. Improved **Cultural Responsiveness**

Success: i) health **workforce representative** of our population
ii) the **right supports IN clinics**: MHAS counsellors, social workers, nurse case managers, pharmacists, navigators

v. Investment in **Health Care Infrastructure**

Success: i) appropriate, complete **staffing** so patients get great care in these great facilities
ii) reliable, timely clinician **access to health information**
ii) **capacity** where needed (LTC, hospitals, addictions care)

Goal II. Responsive Mental Health and Addictions Services

i. **Improved services**

- **Better access and continuity**, inpatient and outpatient
- Plan for **sustainability**

Success: i) embedded **mental health counsellors and chemical dependency counsellors in clinics** for ongoing support
ii) sufficient **inpatient capacity** for timely detox and treatment

The evidence shows that complete transformation to PMH achieves the quadruple aim:

Access

- 84% of studies saw **reduced use of ER and hospitalizations**
- Of those, almost 1/3 studies saw **benefits for chronic disease patients preferentially** in ER use and admissions.
- 79% of pts could get **same day appts**

Health Outcomes

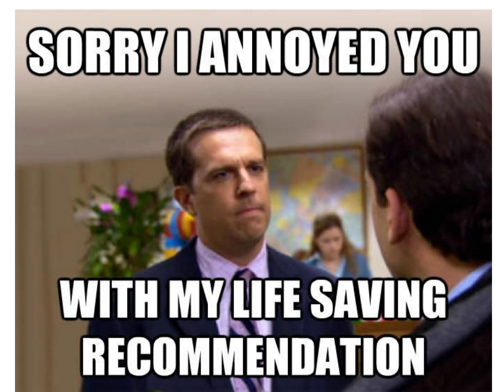
- 12/12 studies found improvements in
  quality of care offered.

- ¼ studies found **full PMH implementation** was associated with **higher scores** than partial

- Various studies found benefits for patients living with **chronic disease** (DM, CAD, PVD, HTN), **mental illness**, pediatric ADHD

Prevention/Screening

- 12/14 studies found **improved rates of screening** in PMH practices
- Higher PMH scores were associated with **higher rates of screening** in several studies
- In one study, **biggest gains from PMH in low SES settings**



Patient Satisfaction

- **14/16 studies saw improvement**.
- 72% reported **access** to a wide range of clinicians
- 68% reported **better understanding** of their medical conditions
- 64% reported **improved ability to self-manage**
- 55% reported having enough **time** with their doctor

Physician Satisfaction

- 40/48 studies saw **high levels** of physician satisfaction
- Training programs report **FP grads trained in PMH clinics choose this model**, decline others.
- Physicians in BC, AB, ON, NS who're in PMH clinics report **ease of recruitment & retention**

Reduced health care costs

19/31 studies showed **lower health care costs** *and* **higher quality of care** by

1. supporting patient self-management, and
2. reducing emergency department visits and hospital readmissions.

Taber Clinic: ANNUAL PER PATIENT COSTS & SAVINGS **2016-17**

ANNUAL COSTS	TABER	ALBERTA RURAL	DIFFERENCE
PRIMARY CARE	$378	$366	$12 higher
OTHER PROVIDERS (e.g. specialists)	$326	$406	$80 lower
EMERGENCY DEPARTMENT VISITS	$162	$274	$112 lower
INPATIENT STAYS	$467	$736	$269 lower

ANNUAL SAVINGS:

Per patient:	$449
For all patients at the Taber Clinic:	$7.2M

10-YEAR SAVINGS:

For all patients at the Taber Clinic (2007-08 to 2016-17):	$62.2M

Crowfoot Village Family Practice (CVFP) ANNUAL PER PATIENT COSTS & SAVINGS **2016-17**

ANNUAL COSTS	CVFP	ALBERTA METRO	DIFFERENCE
PRIMARY CARE	$343	$293	$50 higher
OTHER PROVIDERS (e.g. specialists)	$521	$510	$11 higher
EMERGENCY DEPARTMENT VISITS	$86	$110	$24 lower
INPATIENT STAYS	$298	$517	$219 lower

ANNUAL SAVINGS:

Per patient:	$182
For all patients at the Crowfoot Village Family Practice:	$4.3M

10-YEAR SAVINGS:

For all patients at the Crowfoot Village Family Practice (2007-08 to 2016-17):	$57.3M

Cost Savings in the Patient's Medical Home – Taber and Crowfoot Clinics

$120 million in savings over 10 years.

- Taber can inform SK communities with a single source of care

PMH in Practice: Clinique Medicale Nepisiguit, Bathurst, NB

- Utilization:
  - 38% lower use of ER than patients of other clinics
  - 21% lower rates of hospitalization
  - Lower rates of primary care use
  - Reduced lab and imaging ordering compared to others in province
- Cost Savings:
  - $1,000 per patient per year. Panel is 18,000 patients. So…$18,000,000/yr saved

In good news,

Excellent work is happening to advance the PMH vision in Saskatchewan, and patients are already benefiting.

PATIENT'S MEDICAL HOME

What's underway with regard to Foundations?

- The SMA is collaborating with SHA and Ministry on **remuneration models to address the crisis in primary care.**
- The SHA is funding eHealth to work toward **EMR interoperability**, which infrastructure will allow more connected care.
- The SCFP and the College of Medicine are collaborating with the SHA to improve **access to specialty care and appropriateness of referrals.**

PATIENT'S MEDICAL HOME

How about the arena of functions?

- **Virtual visits** have improved patient access to and satisfaction with care

- Access also improved during the pandemic with a temporary switch to **Open-Access Scheduling**
- **Team Huddles** are increasingly being used in acute care and ambulatory care environments. **Blended payment will help** as all participants will be paid for their time.

PATIENT'S MEDICAL HOME

What Ongoing Development is happening?

- The CoM is advocating for **more spots in medical school and residency** training
- Numerous organizations are advocating to **pay physicians for** more of the **teaching** they do with trainees at all levels

- HQC and the College of Medicine are collaborating on **Physician Panel Reports**
- HQC has developed **CPD on panel management** and **QI in Clinics** is coming!
- HQC is developing **new CPD** to train doctors on data gathering and analysis.
- The SCFP offers **Practice Improvement Essentials CPD** multiple times yearly
- The SMA sponsors multiple **Physician Leadership Institute courses** every year

What is still needed?

- **Investment** in co-located* physician-led teams with dedicated support for practice governance and quality improvement
- **Blended Remuneration** to incentivize patient centered care
- **Interoperable electronic records** to share information across settings in near real time

Why does it matter how we pay docs?

- Cochrane review: FFS **blended** with capitation increases primary care visits (access) with fewer hospital referrals and repeat prescriptions
- Studies show **better quality** with salary or capitation, especially for people with complex medical needs.

Why pay docs via blended capitation?

- Better care for vulnerable populations
- For pts with chronic disease
- Salaried docs saw 2.5-3x more complex pts than FFS docs

- So we have the capacity to alter utilization patterns

Chronic Disease Management

- Clinics with salaried docs (usually low SES patient populations at CHCs) do 10-15% better than any other model for CDM.
- Attributed to longer consults and interprofessional teamwork

PMH takes QI from afterthought to centre stage.

- QI becomes core activity of primary care
- QI time paid as in AB, like primary care
- Deliberate data collection to guide changes in care
- Engages admin staff, non-MD staff to undertake QI activities so doc can focus on care
- Improves retention when all feel engaged in improving care

So, how does QI in PMH look?
One option:

- Individual physicians choose a measure to work on via PDSA cycles
- Share outcomes, successful and not in regular meeting
- If successful, can offer to peers in clinic and out in an accessible way (EMR reports to run, approaches to have MOA/Reception use)

Alternatively,

- Every two weeks, all team members get reports of a selection of measures for their pts:
  - Screening. Who’s up to date?
  - Vaccinations
  - Chronic Disease Mgmt: A1c in DM, BP in HTN, statins offered appropriately
- Super List – for each pt, list all needed
- Best Practice Advisories in the chart when pt seen.

Consider:

SK spends $7000/pt/yr on Health

$50/pt/yr towards primary care redesign represents 0.7% of annual budget per patient

PMH demonstrates cost savings and quality improvement.

We should invest in ourselves.

Questions and Comments?

Dr. Ginger Ruddy
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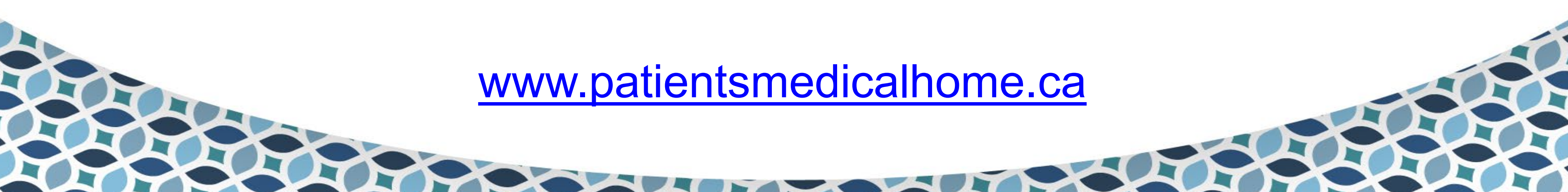


www.patientsmedicalhome.ca

Do you want I♥QI socks?

Become a QI Power Hour speaker!

Visit our website to learn more!

QI in Clinics

Apply for our upcoming QI in Clinics cohort taking place from September to December.

To learn more and to apply check out the link in the chat

A QI approach can support clinics to use system thinking and measurements to drive meaningful changes.

These changes can result in improved performance, eliminated waste, improved patient outcomes, and improved experience for both patients and clinic staff.

Randomized Coffee Trials

Want to connect with other people passionate about quality improvement?

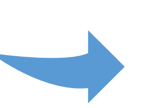
Sign up for our Randomized Coffee Trials

The link to sign up is in the chat

Post webinar survey

In the spirit of quality improvement, we will be sending out a survey after the webinar.

You may see this message, but don't be alarmed, our survey is on a trusted site!



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Next up…

Learning Health Systems in Canada – What do we know?

With DR. GARY GROOT

Date Sept 22, 2023

Time 9:30 am – 10:30 am

To register, visit our events page