Provincial Summaries of Governance Structures for Health and Social Services and Primary Care: A 2018 Canadian Snapshot

Overview: This is supporting material for a 2017-2019 policy scan to describe and compare initiatives across Canada to integrate services across health and social sectors for primary care patients with complex care needs. This document presents the provincial narrative summaries written in 2018 and 2019 that drew from publicly available information from government websites pertaining to provincial institutional authorities that govern primary care, health and social services, macro level policies affecting primary care since 2001 and primary care delivery models. The provincial data were transformed into provincial narrative summaries that were validated by one or more key informants in each province.

Context: Comprehensive primary healthcare for patients with complex care needs requires connection between primary care, other health services, social services and community supports. This comparative policy analysis took stock of progress toward the integration of primary care with health and social services through the lens of the top-10 services needed by children and youth (0-19 years of age) with high functional needs and community-dwelling older adults (≥65 years) experiencing functional decline.

Methodology: This comparative descriptive policy and program analysis was conducted by a pan-Canadian team of 50 researchers, clinical and policy leads and patient partners in the Primary and Integrated Health Care Innovations Network (PIHCIN). Data collection involved information gathering from publicly available websites and documents and key informant interviews to describe provincial and primary care models and governance structures pertaining to the top-10 services for our target groups. All 10 Canadian provinces were represented in the data collection that took place between 2018 and 2019.

Results: Publicly available information was lacking on services and programs which makes cross-jurisdictional learning challenging for policy makers. Governance structures for relevant health and social services vary widely across Canadian provinces, underscoring the fact that provincial health systems are very different. New models for primary care delivery are well-established in most provinces. Integration efforts and policies are still largely focused on medical and health services.

Discussion: While access to a broad range of health services increased after the Medical Insurance Act (Medicare) was introduced in 1966, policies supporting comprehensiveness remain focused on medical and health services. Although there are exemplars of integrated comprehensive care, more policy support is needed to enable integration between health and social services. Making available these provincial summaries is intended to support the efforts of researchers, program evaluators and policy makers to learn across-jurisdictions and to build a centrally available knowledge base to continue efforts in policy analysis pertaining to integrated primary care.

Acknowledgement: This study was supported by the Canadian Institutes of Health Research and 10 different funders. The results are published in a *Special Issue* of *Healthcare Policy*, available at link.

How are Primary Health and Social Services Connecting to one Another in Canadian Provinces for Patients with Complex Care Needs: A 2018 pan-Canadian Comparative Policy and Program Analysis

This comparative descriptive policy and program analysis was lead by the following Principal researchers, clinical and policy leads and patient partners in Primary and Integrated Health Care Innovations Network (PIHCIN). The provincial summaries of governance structures pertaining to integrating primary care with health and social structures were produced by two teams.

Principal Researchers

Jeannie Haggerty, PhD, Nominated Principal Investigator Assistant Scientific Director Réseau-1 Québec, McGill Chair in Family & Community Medicine Research at St. Mary's Hospital, Professor, Department of Family Medicine, McGill University, QC	Catherine Scott, PT, PhD Chief Knowledge & Policy Officer, Policywise Alberta Adjunct Professor, Department of Community Health, University of Calgary, AB
Yves Couturier, MSW, PhD Reseau-1 Québec Scientific Director, Professor, École de travail social, Faculté des lettres et des sciences humaines, Université de Sherbrooke, QC	Amelie Quesnel-Vallée, BSN, PhD Canada Research Chair in PoliciesandHealth Inequalities, Associate Professor, Department of Epidemiology, Biostatisticsand Occupational Health and Department of Sociology, McGill University, QC
Tara Stewart, PhD Assistant Professor, Department of Community Health Sciences, University of Manitoba, Researcher/Evaluator, George & Fay Yee Centre for Healthcare Innovation, Manitoba SPOR SUPPORT Unit, MB	Robyn Urquart, PhD Endowed Chair in Population Cancer Research Associate professor, Department of Community Health and Epidemiology, Dalhousie University, NS
Shelley Doucet, MScN, PhD Jarislowsky Chair in Interprofessional Patient-Centred Care, Associate Professor, Department of Nursing and Health Sciences, University of New Brunswick Saint John, NB	William Montelpare, PhD Margaret and Wallace McCain Chair in Human Development and Health, Professor, Department of Applied Human Sciences, University of PEI, PEI
Jason Sutherland, PhD Associate Professor, Centre for Health Services and Policy Research, University of British Columbia, BC	Nelly D. Oelke, BScN, PhD Assistant Professor, School of Nursing, Faculty of Health and Social Development, University of British Columbia, Okanagan, BC
Emilie Dionne, PhD Program Coordinator and Post-doctoral Fellow, St. Mary's Research Centre and Department of Family Medicine, McGill University, QC	

Patient Partners

Roger Stoddard Patient and family member, NB PIHCI Network, NB	Jim Mann AgeWell, BC

Policy and Clinical Leads

Denis Roy, MD, MSc Vice-president of science and clinical governance, Institut national d'excellence en santé et services sociaux, QC	Jeanette Edwards Director Primary Health Care, Winnipeg Regional Health Authority, MB

Shannon Berg, PhD Executive Director for Primary Health Care, Health Services Delivery Division, Alberta Health, Associate, Center for Clinical Epidemiology and Evaluation, AB	Anne Junker Pediatrician and Clinical Lead of BC PHCRN, Associate Professor, Department of Pediatrics, University of British Columbia, BC
Kevin Chan, MD Clinical Lead, NL PRIIME Network, NL	

Funding

This study was funded by the Canadian Institutes of Health Research (CIHR) and other partners who matched the CIHR funding. We gratefully acknowledge the generous cash and in-kind contributions of the following financial partners:

- Research Manitoba
- New Brunswick Health Research Foundation
- McGill Chair in Family Medicine & Community Medicine Research at St. Mary's (Jeannie Haggerty)
- Réseau de connaissance sur les soins primaire (Réseau-1 Québec)
- Research Chair - Axe Société, populations et services, Centre de recherche sur le vieillissement, CIUSSS de l'Estrie-CHUS (Yves Couturier)
- Institut universitaire de première ligne en santé et services sociaux - CIUSSS de l'Estrie-CHUS
- Canada Research Chair in Policies and Health Inequalities (Amélie Quesnel-Vallée)
- Janeway Foundation, Newfoundland
- Dalhousie University (Robin Urquhart)
- Policywise, Alberta (formerly the Centre for Child, Family & Community Research)

Macro Policy Scan:

The scan of macro policies and governance structures was led by the teams of:

Amelie Quesnel-Vallée, PhD
Canada Research Chair in Policies and Health Inequalities;
Associate Professor, Department of Epidemiology, Biostatistics and Occupational Health and Department of Sociology, McGill University, QC

Tara Stewart, PhD
Assistant Professor, Department of Community Health Sciences, University of Manitoba; Researcher/Evaluator, George & Fay Yee Centre for Healthcare Innovation, Manitoba SPOR SUPPORT Unit, MB

Provincial Summaries

These validated provincial summaries follow the format of the data collection template that was used to gather data (see Appendix). The heading of each provincial summary contains: the date the summary was validated, the names of those who collected the data, and the key informants who validated it. The sources are listed at the end of each summary in the reference list.

Individual provincial summaries are presented in geographic order across Canada, west (British Columbia) to east (Newfoundland and Labrador). Links are to the provincial summaries within the document.

Provincial Summary	Pages	Authors
British Columbia	1-11	Shauna Zinnick & Tara Stewart
Alberta	12-17	Shauna Zinnick & Tara Stewart
Saskatchewan	18-23	Shauna Zinnick & Tara Stewart
Manitoba	24-31	Shauna Zinnick & Tara Stewart
Ontario	32-42	Noushon Farmanara
Québec	43-53	Catherine Labasi-Sammartino & Amélie Quesnel-Vallée
New Brunswick	54-64	Catherine Labasi-Sammartino & Noushon Farmanara
Nova Scotia	65-74	Laura Lee Madden
Prince Edward Island	75-81	Catherine Labasi-Sammartino & Noushon Farmanara
Newfoundland and Labrador	82-91	Laura Lee Madden
Appendix: Data collection template	92-95	

Disclaimer: We acknowledge that these governance structures are dynamic and that changes will likely take place between the time of writing, publication, and reading. The intent of these macro policy scans is to provide a snapshot of provincial governance structures at a particular point in time, in order to identify macro-level similarities and differences across jurisdictions.

TERMINOLOGY:

Primary Health Care: Refers to an approach to health and a spectrum of services beyond the traditional health care system. It encompasses all services (not just medical) that play a part in health, such as income, housing, education, and the environment.

Primary Care: represents the element within primary health care that focuses on health care services, including diagnosis, treatment, health promotion, illness, and injury prevention. Primary care providers include (but are not limited to): family physicians and general practitioners; paediatricians; general internists; geriatricians; nurse practitioners; and other types of nurses. In general, this represents care that is delivered predominantly though *primary care clinics* and *community health centres*.

Last updated: 2018-11-02
Author(s): Noushon Farmanara
Validation: Jason Sutherland, Victoria Schuckel

Macro-Policy Scan: BRITISH COLUMBIA

Part I: Primary Health Care Policy Structure and Scope

1) What is the formal governance structure for primary care (Ministry name, where in the structure is provincial/territorial oversight for primary care)? If possible, include an organizational chart of provincial government department structure, and an organizational chart of the subsidiary branches, departments, or units of the department of health.

- Responsibility for primary care is divided between the Ministry of Health (MoH), which is responsible for overall funding and policies for the province, and regional health authorities (one provincial, and five regional health authorities) that are responsible for service delivery (Levesque et al. 2012).
- Within the MoH, primary care falls under the Primary and Community Care Policy Division of the Health Services Branch. Conceptualized here is the intention of reinforcing the connection between primary and community care and this transformation – where previously, primary care and community care did not fall within the same division (Personal communication, BC Government, Nov. 2, 2018). Funding and funding policy for physician-provided primary care occurs elsewhere within the ministry.
- The MoH funds most physician-provided primary care in the province. The health authorities also fund a small portion of physician-provided primary care (e.g., radiologists are remunerated by health authorities). Non-physician primary care is also funded by the health authorities. Policies regarding primary care delivery are set by the MoH and the health authorities.
- Key entities with regards to primary care include the Ministry of Health, Divisions of Family Practice, and the General Practice Services Committee in BC:
    - The GPSC was created in 2001 under an agreement between the BC MoH and the (then) BC Medical Association (BCMA) – now known as Doctors of BC. The GSPC is one of four collaborative committees that represent partnerships between the BC government and Doctors of BC – and is responsible for reforms related to improving primary care (or 'full-service family practice') and patient care in the province (Cavers et al. 2010).
    - Divisions of Family Practice were launched in 2009 to address isolation of physicians in their practice and to provide family physicians with more capacity to influence healthcare delivery (Misfeldt et al. 2017). They are voluntary groupings or networks of family physicians serving communities within the health authorities. Divisions are incorporated as non-profit societies, giving them legal authority to contract with health authorities and the Ministry, and to hold funds for programs in the community (Mazowita and Cavers 2011).
- Under the new provincial government, additional work has been undertaken in recent months to improve integration of primary health care and the introduction and/or expansion of team-

based models of care. This reform has been occurring through the cross-collaboration of three divisions within the Ministry of Health: Primary and Community Care; Clinical Integration, Regulation, and Education; and the Workforce Compensation, Agreements and Beneficiary Services Division (Personal communication, BC Government, Nov. 2, 2018).

2) What specific services fall under the same governance structure as primary care? (i.e., scope – home care? Social services? End-of-life support? Any public health functions?)

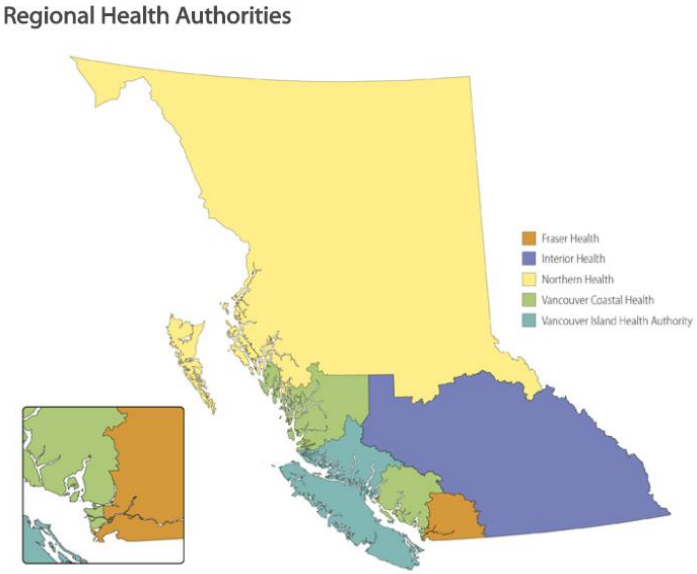
- Within the Health Services Branch of the MoH, five other divisions fall under the same governance structure as primary care: (1) Clinical integration, regulation, and education; (2) Hospital, diagnostic, and clinical services; (3) Partnerships & Innovation; (4) Population and Public Health; and (5) Planning, Compensation & Beneficiary. Services captured within these divisions include: acute and provincial services; laboratory, diagnostic, and blood services; HealthLinkBC services (e.g., dietician services, navigation services, and nursing services); health protection services; healthy living (e.g., healthy settings, injury prevention, and physical activity; tobacco and vapour products program/injury prevention); provincial immunization services and infection control; and women and maternal health services (Government of BC n.d.-a).
- Home care and seniors' services fall within the Primary Care and Community Policy Division. However, it is important to note that the MoH takes more of a 'stewardship' role, rather than acting as a health system manager. Therefore, the activities above may operate at a high-level under the MoH. Nonetheless, the MoH is an active participant with health authorities and the Divisions of Family Practice in BC. Moving forward, the provincial government has indicated that a greater focus will be placed on strengthening the role for other stakeholders, such as community organizations and non-governmental organizations (Personal communication, Nov. 2, 2018).
- Social services generally do not fall under the same governance structure as primary care and may fall under the governance of other ministries related to social development, poverty reduction, housing, and/or child & family development, for example.

3) Is primary care governance and organization decentralized to the regional structures? What are the entities and scopes of responsibility?

- The MoH provides funding through Regional Health Authorities (RHA) for hospital programs, mental health and addictions services, and residential/assisted living.
- The MoH sets the overall direction for the health system in BC (i.e., provides legislative and regulatory frameworks and plans for the future), the supply and deployment of health professionals, technology and facilities (Government of BC, n.d.-b).
- The ministry supports and funds the activities of all RHAs, including all public health programs and services in British Columbia.
- Population and Public Health Division is the focal point for the provincially coordinated and regionally delivered public health system.

- Health authorities are the organizations primarily responsible for health service delivery. Five RHAs (see Fig. 2) deliver a full range of health services, including public health services, within their respective regions (Government of BC n.d.-c):
    - Fraser Health
    - Interior Health
    - Northern Health
    - Vancouver Coastal Health
    - Vancouver Island Health Authority
- Under the Health Authorities Act of 2001, the RHAs and Provincial Health Services Authority (PHSA) were created and mandated to identify needs of their specific populations, plan and provide necessary services, and monitor/report results to the MoH. Each of the six health authorities have their own governance structures (Wong et al. 2010).
- As of August 2018, 11 communities across the province are also engaged in planning and implementing services for local Primary Care Networks (PCN), that will be situated in more local geographical areas within the health authorities (see Q5 for details on PCNs). PCNs will be enabled through a partnership between divisions of family practice and the respective health authorities, with additional support from community partners (General Practice Services Committee 2018).

Figure 1. Distribution of the five Regional Health Authorities (RHA) in British Columbia



- The Provincial Health Services Authority (PHSA) is a sixth regional health authority that was created to work with the five RHAs to manage quality, coordination, and accessibility of province-wide specialized services and programs (e.g., cancer, renal, transplant, and essential provincial health programs; Government of BC n.d.-b).

- Agencies under the responsibility of the PHSA include BC Cancer Agency, BC Centre for Disease Control (BCCDC), BC Children's Hospital and Sunny Hill Health Centre for Children, BC Emergency Health Services, BC Mental Health & Substance Use Services, BC Renal Agency, BC Transplant, BC Women's Hospital + Health Centre, Cardiac Services BC, and Perinatal Services BC.
- Province-wide programs and services include: BC Autism Assessment Network, BC Early Hearing Program, BC Surgical Patient Registry, Health Emergency Management BC, Indigenous Health (i.e. Aboriginal patient liaison training and assisting provincially-focused, community-based initiatives in HIV/AIDS primary prevention/education, and disabilities), Lower Mainland Pathology & Laboratory Medicine, Mobile Medical Unit, Provincial Infection Control Network of BC, Provincial Language Services, Services Francophones, Stroke Services BC, Trans Care BC, Trauma Services BC (Provincial Health Services Authority [PHSA] n.d.).
- The First Nations Health Authority (FNHA) designs, manages, and funds the delivery of First Nations health programs and services. In 2013, the FNHA assumed the responsibilities, programs, and services formerly provided by Health Canada's First Nations Inuit Health Branch – Pacific Region (First Nations Health Authority n.d.).
- Community-based programs are focused largely on health promotion and disease prevention (includes primary health care). These programs are integrated with the services provided by the MoH and the six health authorities.
- Yearly mandate letters (previously referred to as government letters of expectation) are issued to each of the health authorities by the BC government. These letters communicate and outline the annual direction expected for the health authorities by the Ministry of Health and provide accountabilities, roles and responsibilities, and expectations (Wong et al. 2010). Health authorities also make three-year service plans available, which outline the strategic directions and priorities of each health authority over that period.

4) What are the models for delivery of front-line primary care (e.g., autonomous private delivery, reform models by name, community health centres)? What is the approximate proportion and population coverage?

Divisions of Family Practice:

- Introduced in 2009, divisions of family practice are voluntary groupings or networks of family physicians serving communities within the health authorities. By creating networks of physicians at the local level, this was intended to better meet the individual needs of the communities for different programs or services. Currently, there are 35 Divisions of Family Practice operating within their respective health authorities, encompassing over 230 communities. Moreover, over 90% of family physicians in BC are engaged in a division of family practice.

Solo or group-based practices:

- Solo or group-based practices (with fee-for-service reimbursement schemes) are still the predominant model for primary care delivery in BC. Some sessional payments (blended with fee-for-service) may be provided for specific populations (BC Ministry of Health 2015; Wong et al.

2010). The province is also in the early stages of adopting capitation payments for physicians (Personal communication, Nov. 2, 2018).

Community Health Centres (CHCs):

- CHCs are multi-sector healthcare and social services organizations that provide integrated services and programs. CHCs are not-for-profit corporations of co-operatives that share five key characteristics: they provide inter-professional primary care; integrate services/programs in primary care, health promotion, and community well-being; are community-governed and centred; address social determinants of health; and demonstrate commitment to health equity and social justice (British Columbia Association of Community Health Centres n.d.).
- CHC services are delivered through inter-professional teams that may be comprised of family physicians, nurse practitioners, nurses, dieticians, social workers, physiotherapists, dentists, etc. CHCs are primarily funded through the regional health authorities based on contractual agreements with the MoH.

Team-based family practice (emerging model):

- Other than CHCs, interdisciplinary and team-based practices had not historically been a highly developed strategy of care in BC. As opposed to a province-wide model of delivery, local divisions of family practice had (to varying extents) identified and implemented various forms of team-based care as an integral part of strengthening primary care and improving physician attachment within their communities (Hefford 2015).
- A recent report from the Select Standing Senate Committee on Health in BC emphasized the importance of incorporating interdisciplinary primary and community care models into province-wide delivery of primary care – encouraging the provincial government to implement and support these models. Furthermore, the committee recommended that these care models include the integration of health and social services, where appropriate (Select Standing Committee on Health 2017).
- According to 2014 data, approximately 85% of British Columbians (aged 12 years and older) had access to a regular medical doctor (Canadian Institute for Health Information 2014). The role of Nurse Practitioners (NP) has also been extended in BC within the Health Professions Act.
- Various projects funded by health authorities have aimed to integrate NPs into different Primary Health Care (PHC) settings. In 2000, 12% of registered nurses worked in a PHC setting; in 2006, this figure was approximately 15% (Wong et al. 2009; Watson et al. 2009).
- In May 2018, the BC government also announced a commitment to provide funding in order to create 200 NP positions in primary care settings throughout the province, as well as 30 new spots for NP education (Government of BC 2018). NPs will also be supported in integrating within primary care practices, and in establishing NP-led primary and community care clinics.

5) What are the main reform models of primary care or primary health care (list & briefly describe)?

Last updated: 2018-11-02
Author(s): Noushon Farmanara
Validation: Jason Sutherland, Victoria Schuckel

In May 2018, the new BC government announced the launch of a new primary health-care strategy in the province, with a new focus on team-based care (Government of BC 2018). As part of this renewed strategy, the government would be putting in place:

Primary Care Networks: A PCN is a clinical network of local primary care services providers. Within these networks, physicians, other primary care providers, allied health care providers, health authority service providers, and community organizations collaborate to provide primary care services for the local population. Acting as the backbone of the team-based approach, PCNs would allow patients to access variety of health-care services and act to streamline connections between various providers (General Practice Services Committee 2018). Networks will be rolled out in at least 15 communities over the course of the year, with plans to implement across 70% of communities in BC over the next three years. As of August 2018, 11 communities in BC are engaged in planning and implementing services for local PCNs.

Urgent primary care centres: new to the province, these centres would provide primary care to patients who are not attached to a family doctor or nurse practitioner, with the intent of relieving pressure off hospital emergency departments. Ten centres are proposed to be established over the course of the year.

Community Health Centres: CHCs will bring together health and broader social services. CHCs are intended to be developed in accordance with the needs of the community in which they are placed and fully integrated into the local primary care networks.

In addition, a Primary and Community Care Advisory Committee was created to support this renewed primary health care strategy. The objective of the committee will be to provide strategic direction, advice and guidance to the Ministry of Health on research and evaluation activities supporting the implementation of team-based primary and community care in BC.

Patient Medical Home (PMH):

- In recent years, there has been a movement (largely initiated by local divisions of family practice) to incorporate team-based care models and to better integrate primary care with other services.
- In 2011 the College of Family Physicians of Canada (CFPC) released a report on the future vision for family practice in Canada through the Patient's Medical Home (PMH). The CFPC defined its vision of the PMH as a family practice and place where patients are most comfortable to "present and discuss their personal and family health and medical concerns [and as a] central hub for the timely provision and coordination of (...) comprehensive (…) health and medical services [that] patients need" (College of Family Physicians of Canada 2011).
- The GPSC has drawn on the framework and definitions put forward by the CFPC and adapted a vision for the patient medical home in BC. A PMH is a family physician practice where patients receive the majority of their care. Building on existing structures, key characteristics of the PMH include:

- greater use of EMR to plan care;
- inter-disciplinary teams with support from allied health professionals and other providers;
- physician networks for peer and patient support; and are,
- situated within Primary Care Network, to simplify linkages to a range of providers that are integral to care (General Practice Services Committee 2016).

"A GP for Me":

- Province-wide initiative was targeted towards providing British Columbians with access to a family physician. The initiative was funded by the Government of BC and Doctors of BC starting in 2013, with directed funding running until 2016 (Divisions of Family Practice n.d.-b).
- Program included investments over the two-year program period for new fees available to family physicians with regards to patient attachment and better support for patients with complex care needs. Examples of fees included payments for signing up new patients, providing telephone management/consultation, and provision of expanded care for complex patients.
- Additional support was provided to Divisions of Family Practice over this period in order to identify unmet needs for family physicians at the local level and to develop plans to improve primary care capacity and to link unattached patients (seeking a family physician) with a provider.

Practice Support Program (PSP):

- The PSP was established by the GPSC to address the decline in family practice (e.g., GPs leaving full-service family practice, limiting services provided in family practices) taking place in BC during the 1990s (MacCarthy et al. 2009).
- The GPSC held consultations in 2004 and 2005, referred to as 'Professional Quality Improvement Days', with approximately 1000 general practitioners across the province. These consultations were used to inform the GPSC on how to address the declines. A major response from physicians was the lack of adequate continuing training and support to manage patients with increasingly complex care needs.
- The PSP was developed to address the needs identified in the consultations. The modules were first made available to family practices in 2007 through in-person, peer-group learning sessions (MacCarthy et al. 2009). Initially, the following modules were developed:
    - **Advanced Access**: targeted towards streamlining office administration and scheduling to prevent backlog and improve system efficiency in scheduling and patient management.
    - **Chronic Disease Management**: optimizing care for patients with chronic diseases. Again, this was focused on streamlining practices through utilization of patient registries and automated recall systems to promote regular follow-up and continuity of care.
    - **Patient Self-Management/Group Medical Visits:** utilizing group medical visits to improve outcomes for patients with the same long-term or chronic conditions and to provide tools/information to improve self-management of chronic conditions and health literacy.

- Since 2007, the program has evolved to include sessions in nine key areas of care: adult mental health; advanced access/office efficiency; child and youth mental health; chronic disease management; COPD/heart failure; end-of-life; group medical visits; musculoskeletal; and pain management (General Practices Services Committee n.d.).

Full-Service Family Practice Incentive Program:

- Introduced and implemented by the GPSC in 2003, the program provides financial incentives for physicians to provide care for particular chronic and complex care patients. (Tregillus and Cavers 2011) As part of this, the program also encouraged physicians to transition from solo to group-based practices in areas of need.
- Since 2003, a number of incentives have been introduced that encourage coordinated and longitudinal care in seven key areas: (1) patient attachment; (2) chronic disease management (focused on diabetes, hypertension, COPD, and congestive heart failure); (3) complex care (two or more qualifying chronic diseases); (4) 'patient conferencing' or coordinating care with other providers – specifically for patients in the following categories: frail elderly, palliative care, end-of-life, mental illness, multiple medical needs or complex co-morbidity; (5) maternity care; (6) mental health care; and (7) palliative care.

General Practice Services Committee (GPSC):

- Created in 2001, the GSPC is one of four collaborative committees that represent partnerships between the BC government and Doctors of BC – and is responsible for reforms related to improving primary care (or 'full-service family practice') and patient care in the province (Cavers et al. 2010).
- Full-service family practice was defined by the GPSC as a style of practice encompassing dimensions such as: health assessments; coordination of patient care (across the spectrum of care); continuity of care (longitudinal); services for acute and chronic conditions; primary reproductive care; maternity care (e.g., connecting with other providers for prenatal, obstetrical, and newborn care); primary mental healthcare; primary palliative care; geriatric care and support; support in alternative settings (e.g., hospital, home, etc.); patient education and preventive care; record-keeping; after-hours access (e.g., connecting with care outside of regular office hours; Lavergne et al. 2010).

Primary Health Care Charter:

- The BC government released the *Primary Health Care Charter* (the Charter) in 2007, which outlined the challenges in primary health care for BC, identified priorities, and established select outcome measures in order to establish the strategic direction of the MoH and the regional health authorities (BC Ministry of Health 2007).
- The Charter identified key structural and system changes that would be required to improve primary health care in the province from a high-level perspective. Seven priority areas for primary health care system change were proposed:

  - Improved access to primary health care.
  - Increased access to primary maternity care.
  - Increased chronic disease prevention.
  - Enhanced management of chronic diseases.
  - Improved coordination and management of co-morbidities.
  - Improved care for the frail elderly.
  - Enhanced end-of-life care.
- Key items included:
  - Establishing regional practice support teams that provide expertise for clinical, practice, and IM/IT transformation. These teams provide direct support and peer mentoring for family physicians, practice staff, and other health care professionals to engage in clinical and practice changes. Working in partnership with family physicians these teams would work within the local community to integrate primary health care.
  - Implementing integrated health network teams. Networks would serve a particular geographic community and link family physicians with existing health authority and community resources.

References:

British Columbia Association of Community Health Centres. (n.d.). What are community health centres? Retrieved from: http://www.bcachc.org/what-is-a-chc/.

BC Ministry of Health. (2007). Primary Health Care Charter: a collaborative approach. Victoria, BC: BC Ministry of Health Services. Retrieved from: https://open.library.ubc.ca/media/stream/pdf/52383/1.0048529/1.

BC Ministry of Health. (2015). Primary and community care in BC: A strategic policy framework. Cross sector policy discussion paper. Retrieved from: https://www.health.gov.bc.ca/library/publications/year/2015/primary-and-community-care-policy-paper.pdf.

Canadian Institute for Health Information. (2015). Your health system: Have a regular doctor details in British Columbia. Retrieve from: https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/indicator/001/2/C9001/.

Cavers, W. J., Tregillus, V. H., Micco, A., & Hollander, M. J. (2010). Transforming family practice in British Columbia: The General Practice Services Committee. *Canadian Family Physician*, *56*(12), 1318-1321.

College of Family Physicians of Canada. (2011). A vision for Canada: Family practice – the patient's medical home. Position paper. Retrieved from: http://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/PMH_A_Vision_for_Canada.pdf.

Divisions of Family Practice. (n.d.-a). About us. Retrieved from: https://www.divisionsbc.ca/provincial/about-us.

Divisions of Family Practice. (n.d.-b). Funding announced for 'A GP for Me' (attachment) and in-patient care initiatives. Retrieved from: https://www.divisionsbc.ca/provincial/displayitem?li=270.

First Nations Health Authority. (n.d.). About the FNHA. Retrieved from: http://www.fnha.ca/about/fnha-overview.

General Practice Services Committee. (n.d.). What we do. Retrieved from: http://www.gpscbc.ca/what-we-do.

General Practice Services Committee. (2018). What we do: Primary Care Networks. Retrieved from: http://gpscbc.ca/what-we-do/patient-medical-homes/primary-care-networks.

General Practice Services Committee. (2016). Patient medical home (PMH). Retrieved from: http://www.gpscbc.ca/what-we-do/primary-care-bc/patient-medical-home.

Government of BC. (n.d.-a). B.C. Government Directory: Health Services. Retrieved from: https://dir.gov.bc.ca/gtds.cgi?show=Branch&organizationCode=HLTH&organizationalUnitCode=PCCP.

Government of BC. (n.d-b). About public health: For the public. Retrieved from: https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/about-public-health/for-the-public#organized.

Government of BC (n.d.-c). Regional health authorities. Retrieved from: https://www2.gov.bc.ca/gov/content/health/about-bc-s-health-care-system/partners/health-authorities/regional-health-authorities.

Government of BC. (2018). B.C. government's primary health-care strategy focuses on faster, team-based care. News release. Retrieved from: https://news.gov.bc.ca/releases/2018PREM0034-001010.

Hefford, B. (2015). Team-based care emerges as a widespread strategy for A GP for Me. BC Med J. 57(3), 112.

Lavergne, M. R., Peterson, S., McKendry, R., Sivananthan, S., & McGrail, K. (2014). Full-service family practice in British Columbia: policy interventions and trends in practice, 1991–2010. *Healthcare Policy*, *9*(4), 32.

Levesque, J. F., Pineault, R., Grimard, D., Burge, F., Haggerty, J., Hogg, W., ... & Wong, S. (2012). Looking backward to move forward: A synthesis of primary health care reform evaluations in Canadian provinces. Montreal: Agence de la santé et des services sociaux de Montréal/Direction de santé publique and Institut national de santé publique du Québec.

MacCarthy, D., Kallstrom, L., Gray, R., Miller, J. A., & Hollander, M. J. (2009). Supporting family physicians in British Columbia: the experience of the Practice Support Program. *BC Med J*, *51*(9), 394-7.

Mazowita, G., & Cavers, W. (2011). Reviving full-service family practice in British Columbia. *Issue brief (Commonwealth Fund)*, *19*, 1-20.

Misfeldt, R., Suter, E., Mallinson, S., Boakye, O., Wong, S., & Nasmith, L. (2017). Exploring Context and the Factors Shaping Team-Based Primary Healthcare Policies in Three Canadian Provinces: A Comparative Analysis. *Healthcare Policy*, *13*(1), 74-93.

Provincial Health Services Authority. (n.d.). Our services. Retrieved from: http://www.phsa.ca/our-services.

Select Standing Committee on Health. (2017). Looking forward: Improving rural health care, primary care and addiction recovery programs. Legislative Assembly of British Columbia. Retrieved from: https://www.leg.bc.ca/content/CommitteeDocuments/40th-parliament/6th-session/health/Health_20170301_Report_LookingForward.pdf.

Tregillus, V., & Cavers, W. (2011). General practice services committee: improving primary care for BC physicians and patients. *Healthcare Quarterly*, *14*, 1-6.

Watson, D., & Wong, S. (2005). *Canadian policy context: interdisciplinary collaboration in primary health care*. Enhancing Interdisciplinary Collaboration in Primary Health Care. Retrieved from: http://tools.hhr-rhs.ca/index.php?option=com_mtree&task=att_download&link_id=5305&cf_id=68&lang=en.

Wong, S.T., MacDonald, M., Valaitis, R.K., Kaczorowski, J. Munroe, V., and Blatherwick, J. (2009). An environmental scan of primary care and public health in the province of British Columbia. Vancouver: Centre for health services and policy research, University of British Columbia. Retrieved from: https://open.library.ubc.ca/cIRcle/collections/facultyresearchandpublications/52383/items/1.0048529.

Last updated: 2018-03-16
Author(s): Shauna Zinnick, Tara Stewart
Validation: Cathie Scott, Maeve O'Beirne, Shannon Berg

Macro Policy Scan: ALBERTA

Part I: Primary Health Care Policy Structure and Scope

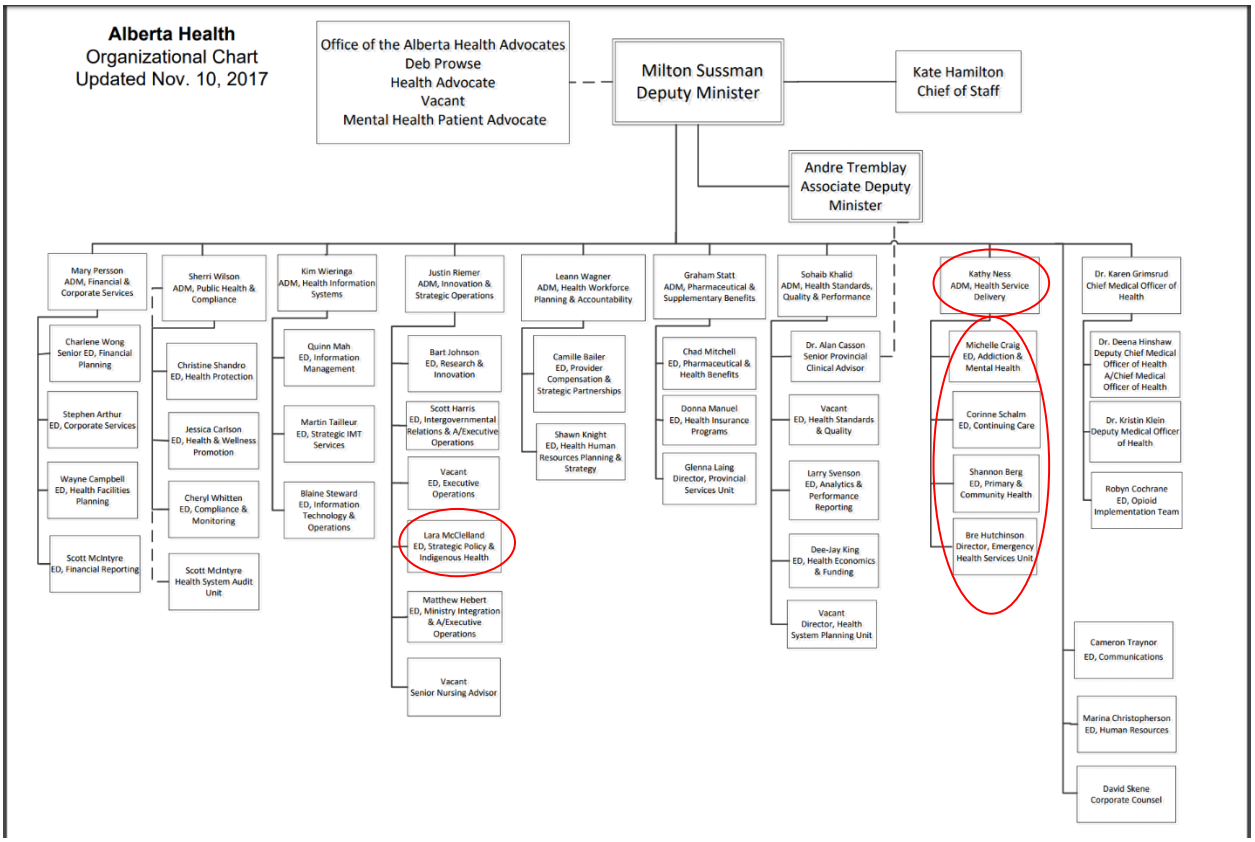
1) What is the formal governance structure for primary care (Ministry name, where in the structure is provincial/territorial oversight for primary care)? If possible, include an organizational chart of provincial government department structure, and an organizational chart of the subsidiary branches, departments, or units of the department of health.

Current Cabinet: The Alberta cabinet is composed of nineteen (19) ministries, one of which is the Ministry of Health. The current Government has been in place since May 24, 2015, following the May 5, 2015 Alberta general election. Members are listed in order of precedence. There was a cabinet shuffle on October 22, 2015 (Bennett 2017). A second shuffle occurred February 2, 2016. Minor shuffles occurred January 19 and October 17, 2017.

Portfolio	Minister	Appointment Date	Riding
Premier of Alberta President of Executive Council	Rachel Notley	May 24, 2015	Edmonton-Strathcona
Deputy Premier of Alberta Minister of Health	Sarah Hoffman	February 2, 2016	Edmonton-Glenora
Minister of Transportation Government House Leader	Brian Mason	May 24, 2015	Edmonton-Highlands-Norwood
Minister of Education	David Eggen	May 24, 2015	Edmonton-Calder
Minister of Economic Development and Trade Deputy Government House Leader	Deron Bilous	May 24, 2015	Edmonton-Beverly-Clareview
Minister of Finance President of Treasury Board	Joe Ceci	May 24, 2015	Calgary-Fort
Minister of Justice and Solicitor-General	Kathleen Ganley	May 24, 2015	Calgary-Buffalo
Minister of Environment and Parks Minister Responsible for the Climate Change Office	Shannon Phillips	May 24, 2015	Lethbridge-West
Minister of Agriculture and Forestry Deputy Government House Leader	Oneil Carlier	May 24, 2015	Whitecourt-Ste. Anne
Minister of Municipal Affairs	Shaye Anderson	January 19, 2017	Leduc-Beaumont
Minister of Energy	Margaret McCuaig-Boyd	May 24, 2015	Dunvegan-Central Peace-Notley
Minister of Community and Social Services	Irfan Sabir	January 19, 2017	Calgary McCall
Minister of Children Services	Danielle Larivee	January 19, 2017	Lesser Slave Lake
Minister of Seniors and Housing	Lori Sigurdson	February 2, 2016	Edmonton-Riverview

Minister of Indigenous Relations	Richard Feehan	February 2, 2016	Edmonton-Rutherford
Minister of Labour Minister Responsible for Democratic Renewal	Christina Gray	February 2, 2016	Edmonton-Mill Woods
Minister of Service Alberta Minister of Status of Women	Stephanie McLean	February 2, 2016	Calgary-Varsity
Minister of Culture and Tourism	Ricardo Miranda	February 2, 2016	Calgary-Cross
Minister of Advanced Education	Marlin Schmidt	February 2, 2016	Edmonton-Gold Bar
Associate Minister of Health	Brandy Payne	February 2, 2016	Calgary-Acadia
Minister of Infrastructure	Sandra Jansen	October 17, 2017	Calgary-North West

Figure 1. Alberta Health organizational chart (Red circles refer to the units closest to primary care.)



2) What specific services fall under the same governance structure as primary care? (i.e., scope – home care? Social services? End-of-life support? Any public health functions?

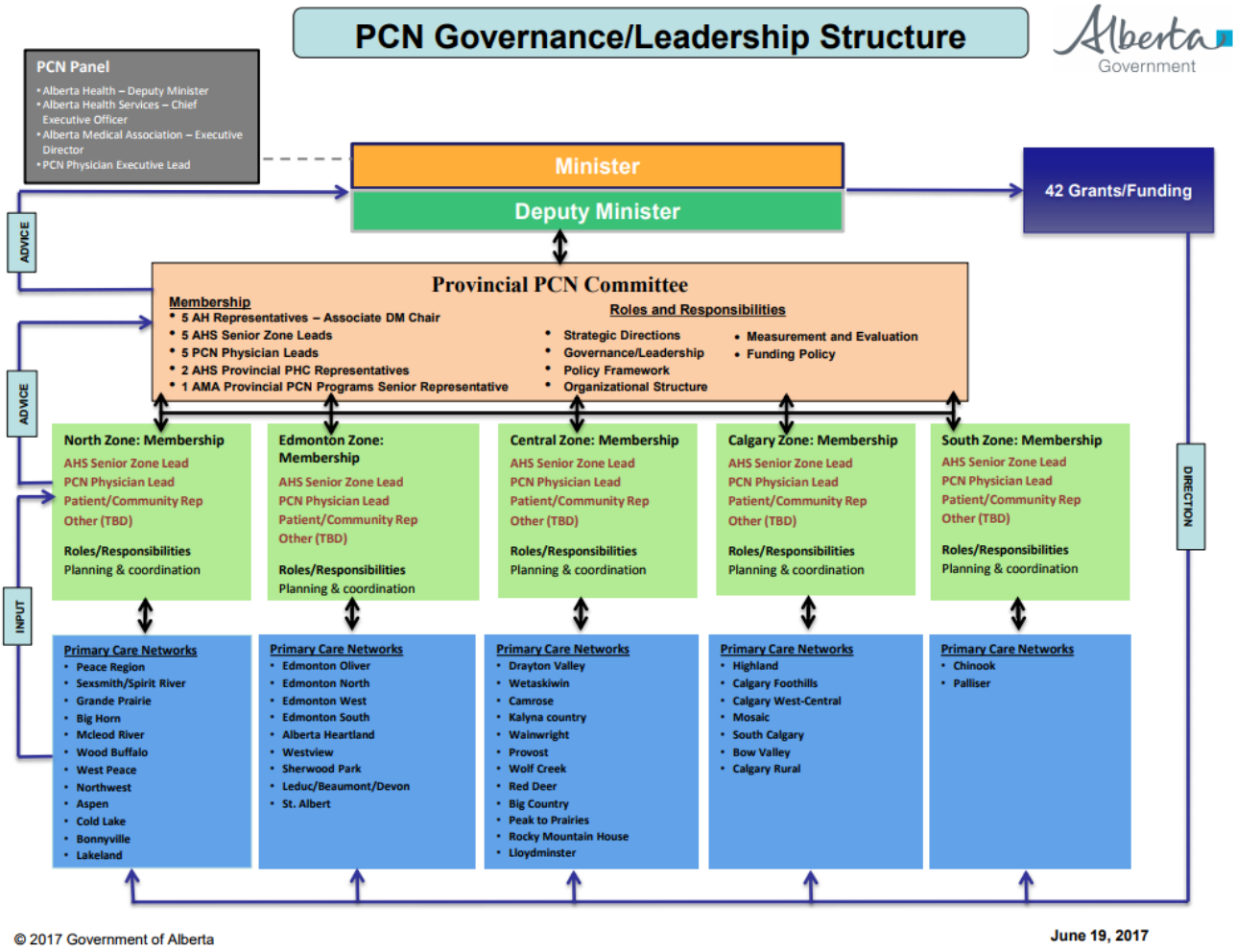
Currently, at the policy level, Addictions & Mental Health, Continuing Care (including home care and end-of-life support), and Emergency Health Services fall within the same broad portfolio as Primary and Community Care. Public Health is a separate division (Public Health & Compliance), which includes

health protection, health and wellness promotion, compliance and monitoring, and the health system audit unit. Strategic Policy and Indigenous Health fall under the portfolio of Innovation and Strategic Operations. Most social services fall under the Ministry of Community and Social Services (social-based programs, abuse and bullying supports, disability services, family services, and financial support services), Ministry of Seniors and Housing (seniors' programs, housing programs) and the Ministry of Children's Services (children's mental health programs, early childhood development supports; Government of Alberta, n.d.).

3) Is primary care governance and organization decentralized to the regional structures? What are the entities and scopes of responsibility?

- Alberta Health Services (AHS) is the single health authority for the province of Alberta. AHS delivers medical care, including primary care, on behalf of the Government of Alberta's Ministry of Health (Alberta Health Services 2017).
- Primary medical care is primarily delivered by independent family physicians/clinics who receive funding directly from the Ministry of Health, either via fee-for-service payments or through Alternate Relationship Plan (ARP) arrangements to physicians.
- Team-based primary health care is primarily provided through Primary Care Networks (PCNs) that are grant funded through the ministry using a per capita based formula.
- A new PCN Provincial Committee has been established to play a governance role over PCNs.
- Approximately 80% of family physicians have registered with a PCN, thus, not all primary care is delivered through member clinics of PCNs.
- Alberta Health Services (AHS) provides some primary health care services by working with Primary Care Networks (PCNs), and through three AHS owned and operated Family Care Clinics.

Figure 2. PCN Governance and Leadership Structure



4) What are the models for delivery of front-line primary care (e.g., autonomous private delivery, reform models by name, community health centres)? What is the approximate proportion and population coverage?

Primary medical care in Alberta is delivered primarily by family physicians in independent practice. Interdisciplinary primary health care services are delivered primarily through the Primary Care Networks (PCNs). Over 80% of family physicians in Alberta are members of a PCN. In addition, some primary health care is provided in family care clinics (three owned and operated by AHS); and community health centres (four that have community boards and provide primary care services in addition to other social and health-related services). Approximately 85 percent of Albertans (3.6 million) have received primary medical care through primary care networks (Government of Alberta 2017).

5) What are the main reform models of primary care/primary health care (list & briefly describe)? What is the accountability agreement of primary care reform models providers to ministries of health? Is there a mandate for service coordination with other structures?

Primary Care Networks (PCN): There are 42 primary care networks in Alberta which include over 3 800 physicians and approximately the equivalent of 1 000 full-time positions for other health care professionals (e.g., nurse practitioners, nurses, dietitians, social workers, and pharmacists; Government of Alberta 2017). Primary care networks were first implemented in 2003 and were designed to provide better access to care, greater health promotion, better chronic disease management, improved care coordination, and the increased use of interdisciplinary teams to provide care. A PCN can be comprised of one clinic with multiple physicians and health care providers working under one roof or can be several different physicians and care providers working in the same geographic area (Alberta Health 2018).
PCN funding is based on patient encounters with primary care providers who are members of a PCN (family physicians, pediatricians, and nurse practitioners). Physicians who join PCNs continue to be compensated for provision of insured medical services through fee-for-service or an alternative relationship plan. Since April 1, 2008, funding for each PCN has been calculated using a "four-cut" funding model applied to all patient encounters within a 36-month period. This funding is intended for primary health care services beyond those provided under insured services such as salaries for providers and programs supporting population health, wellness, and chronic condition and disease prevention and management.

PCN funding supports enhanced staffing (including administrative support), costs related to equipment and premises, chronic disease management, extended office hours, and 24/7 access to appropriate primary care (Alberta Health 2018).

Primary Care Network member physicians recently voted in June 2017 to ratify the PCN Governance framework. A new governance structure has been created that includes a provincial PCN Committee and a PCN committee and five PCN zone committees reporting to the Provincial PCN Committee. The Provincial PCN Committee is responsible for leadership, strategic direction, and priorities for all the PCNs. It is intended to help strengthen relationships between PCNs, AHS and communities.

The five Zone PCN Committees will be responsible for developing zone-wide service plans to align the PCN services provided with population health needs in each specific zone.

Family Care Clinics: Owned and operated by AHS, these clinics were created in Alberta in 2012 to provide individual and family-focused primary health care services to meet the health needs of the community. These Family Care Clinics coordinate a wide range of primary health care services that help to address their patients' health and social needs. Family Care Clinics offer extended hours and provide same-day access to family physicians, nurse practitioners, registered nurses, dietitians, pharmacists, mental health professionals, and other providers (Alberta Health 2017b). There are currently three Family Care Clinics in Alberta (Slave Lake, Edmonton, and Calgary).

Community Health Centres: Community health centres (CHC) are "frontline health care and social support centres" that were established to provide primary health services that integrate team-based

primary medical care with health promotion, social services, and community programs to help address social barriers to health (Alberta Health 2017b). The CHCs also provide assistance with navigating the health system (e.g., hospital discharge planning, coordinating continuing care). In the province, five CHCs serve vulnerable communities such as the homeless, immigrants and refugees, Indigenous populations, and LGBTQ populations. The five CHCs that are members of the AACHC/CACHC are community-governed non-profit organizations. There are AHS facilities with CHC in the title, but it is not clear that these are all CHCs (e.g., Peace River Community Health Centre is an approved hospital).

References:

Alberta Health (2018) Primary Care Networks Governance. Retrieved from: http://www.health.alberta.ca/initiatives/primary-care-networks-governance.html

Alberta Health (2017). Primary Health Care. Government of Alberta. Retrieved from: http://www.health.alberta.ca/services/primary-health-care.html

Alberta Health (2017b). Primary Health Care models. Government of Alberta. Retrieved from: www.health.alberta.ca/services/primary-health-care-models.html

Alberta Health Services (2017). Alberta Health Services Annual Report, 2016-17. Retrieved from: http://www.albertahealthservices.ca/assets/about/publications/ahs-pub-2016-2017-annual-report.pdf.

Alberta Health Services (2017b). "Corporate Organization." Retrieved from: http://www.albertahealthservices.ca/about/Page11884.aspx.

Bennett, D. "Notley shuffles cabinet to focus on Alberta's economic diversification." The Globe and Mail, 25 March 2017. https://www.theglobeandmail.com/news/politics/notley-shuffles-cabinet-to-focus-on-albertas-economic-diversification/article26936786/.

Government of Alberta (n.d.). Retrieved from: https://www.alberta.ca/premier-cabinet.aspx
Government of Alberta (2017). "Ministry of Health Organizational Chart." Alberta Health. Retrieved from: http://www.health.alberta.ca/documents/Org-Chart-Health-2017-11.pdf

Last-updated: 2018-09-19
Author(s): Shauna Zinnick, Tara Stewart
Validation: Karen Scherle

Macro Policy Scan: SASKATCHEWAN

Part I: Primary Health Care Policy Structure and Scope

1) What is the formal governance structure for primary care (Ministry name, where in the structure is provincial/territorial oversight for primary care). If possible, include an organizational chart of provincial government department structure, and an organizational chart of the subsidiary branches, departments, or units of the department of health.

The Saskatchewan cabinet is composed of fourteen (14) ministries, one of which is the Ministry of Health. Within the SK Ministry of Health there exists a Primary Health Services Branch. Of note, two other potentially relevant branches (the Medical Services Branch and the Strategy and Innovation Branch) are also within the same Assistant Deputy Minister's portfolio as the Primary Health Services (Government of Saskatchewan, n.d.).

Figure 1. Saskatchewan cabinet structure.

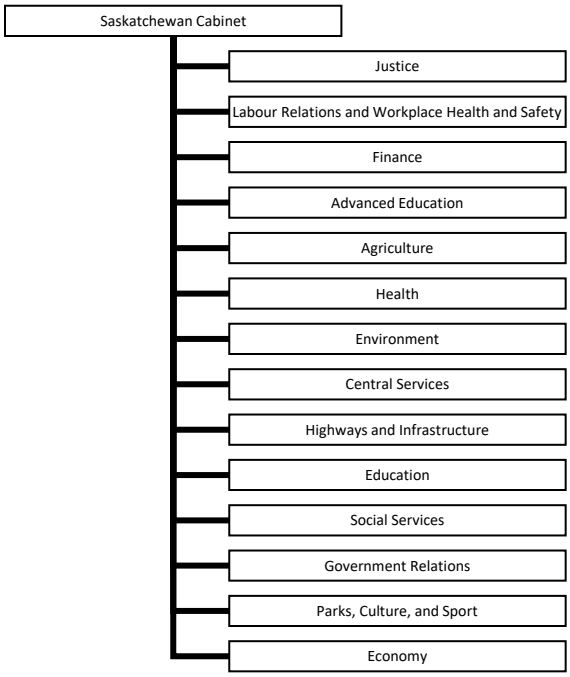
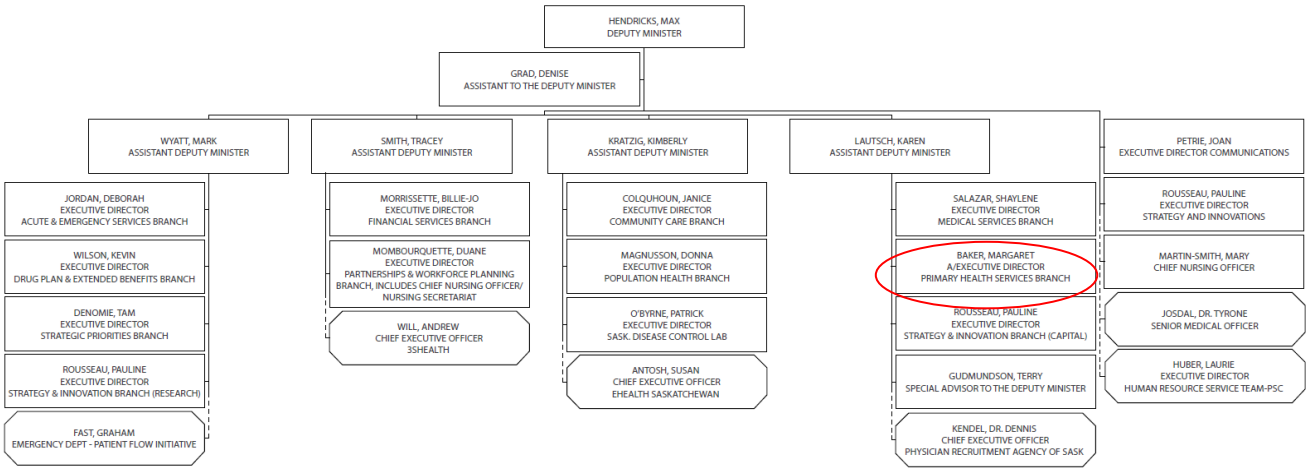
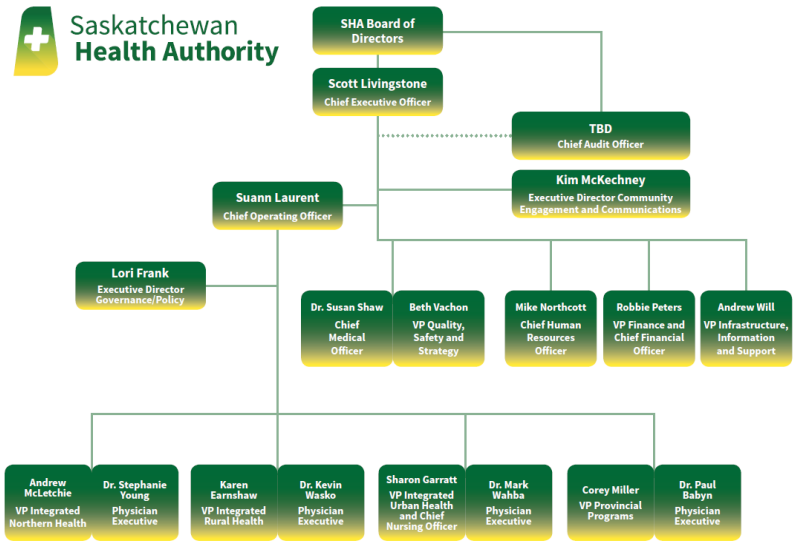


Figure 2. **Ministry of Health Organizational Chart** (Red circle refers to the units closest to primary care.)



Government of Saskatchewan (2016)

Figure 3. **Saskatchewan Health Authority Organizational Chart**



2) What specific services fall under the same governance structure as primary care? (i.e., scope – home care? Social services? End-of-life support? Any public health functions?

At the policy level, the Primary Health Services branch is in the same broad portfolio as Medical Services and Strategy and Innovation. The Primary Health Services branch focuses on Primary Health Care and Health Promotion. Home care falls under a separate portfolio within the Community Care Branch; Public Health Care falls under yet another portfolio within the Population Health Branch. Most social services fall under the Ministry of Social Services.

3) Is primary care governance and organization decentralized to the regional structures? What are the entities and scopes of responsibility?

Up until very recently (2017), primary health care governance and organization was decentralized to twelve (12) regional health authorities and the Athabasca Health Authority (which was not technically a regional health authority but was funded by the provincial and federal governments to provide health services to the region of the Athabasca Basin (Government of Saskatchewan, n.d.). The regional health authorities and the Saskatchewan Cancer Agency were responsible for the delivery of health care services on behalf of the province of Saskatchewan. However, in January 2017, the Saskatchewan government announced the consolidation of 12 health regions in Saskatchewan into one provincial health authority, to be known as the Saskatchewan Health Authority (SHA; Graham 2017). The recommendation to consolidate the health regions into a singular system came from an advisory panel appointed by the Minister of Health in August 2016. Legislation was tabled at the end of March 2017 and the transition to the SHA officially took place on December 4, 2017. The new SK *Provincial Health Authority Act* will:

- Remove the previous regional health authority boundaries;
- "Provide oversight of compensation levels to the contracts of the CEO and those that report to the CEO;"
- Allow Community Advisory Networks to be continue (and be created as necessary) to help ensure all community needs and interests are identified and addressed;
- Ensure donations that are raised by local foundations continue to be used as they were intended, for local health services and facilities;
- Establish the specific roles and responsibilities of the Minister of Health and the Provincial Health Authority; and
- Repeal The Regional Health Services Act.

The structure or composition of the Saskatchewan Health Authority has been outlined (Figure 3; Government of Saskatchewan 2017). The intent of restructuring the health authorities into one body was to create a singular system that was able to meet patient needs through "seamless, integrated and team-based care" (Abrametz et al. 2016). The province was divided into six service integration areas: Regina; Saskatoon; Northeast; Northwest; Southeast; and Southwest.

The leadership structure of the SHA is divided into the following areas: Integrated Northern Health, Integrated Rural Health, Integrated Urban Health, and Provincial Programs within the SHA. Each of those is composed of a Vice-President (VP)-physician dyad: a physician works with an administrator at the VP-level. Physicians in these positions are employees of the health authority and work jointly with administrators to make decisions. At the executive director level (under each VP-Physician dyad), similar dyads don't yet exist, but discussions are underway to determine if continuing with the dyad model at the next level of the organizational structure will have an impact on decision-making, especially for primary health care.

Northern, rural and urban health all have executive directors of acute care, continuing care and primary health care. Urban health has additional executive directors of mental health as urban centres (Regina and Saskatoon) have more specialized mental health services. In northern and rural areas, the executive director of primary health care is responsible for the oversight and integration of primary care, therapies, public health, population health, home care, mental health and medical health officers.

Together with the Saskatchewan Cancer Agency, the Saskatchewan Health Authority is responsible for the delivery of health care services on behalf of the province of Saskatchewan. Once all changes are finalized within the newly formed Saskatchewan Health Authority, the Ministry will undergo change as well to better align with the SHA. For example, provincial programs under the SHA may include services that meet the needs of the province as a whole. The ministry will have to re-structure to ensure there is a good fit between SHA and the Ministry in how these services are governed and provided.

4) What are the models for delivery of front-line primary care (e.g., autonomous private delivery, reform models by name, community health centres)? What is the approximate proportion and population coverage?

Primary care is delivered by a number of different models in Saskatchewan, including private FFS physicians/medical clinics, community health centres, community clinics, northern medical services, and collaborative emergency centres.

Community health centres: in the process of being developed. The first centres will be located in Regina and Saskatoon.

Community clinics: There are 4 community clinics operating in the province, separate from the SHA. These clinics have their own structures and are governed by their own independent boards.

Northern medical services: work with the SHA but are responsible for providing physician services to northern and remote communities.

Collaborative Emergency Centres (CEC): Currently five in the province (Maidstone, Shaunavon, Canora, Spiritwood and Wakaw). The CECs provide communities with primary health care during the day and access to urgent care after hours (Government of Saskatchewan, n.d.). The first CEC opened in Maidstone in September 2013 and is open 24/7 as well as Shaunavon and Canora. These three are staffed with a primary health team (including physicians, nurse practitioners) during the day and overnight with a registered nurse and paramedic to provide care with oversight from an emergency physician from the Shock Trauma Air Rescue Society (STARS[1]). The primary care physicians in these

[1] STARS is a Canadian non-profit helicopter air ambulance organization funded by individual donors, service groups, corporate donors and government contributions. STARS provides rapid and specialized emergency care and transportation for critically ill and injured patients. STARS currently operates three bases in Alberta, two bases in Saskatchewan, and one base in Manitoba.

communities are available during the day. From 8 PM until 8 AM, a registered nurse and paramedic are available. This two-person team works together to assess the patient and consult with a STARS physician. They are able to treat and release, treat and refer (provide the patient with an appointment the following morning to see the local physician) or treat and transfer (if immediate care is required; patient would be transferred to nearest emergency department via ambulance). The CECs in Spiritwood and Wakaw are a modified version. For example, the Wakaw CEC does not have a registered nurse on duty overnight. Rather, two paramedics are available and neighbouring physicians provide on-call support, not STARS physicians. These two CECs may also not be open 24/7.

In 2012 the Government released a Framework entitled *"Patient Centered, Community Designed, Team Delivered: A Framework for Achieving a High Performing Primary Health Care System in Saskatchewan.* Eight primary health care innovation sites(Leader, Lloydminster, Meadow Lake, Moose Jaw, Saskatoon Health Region partnership with Whitecap Dakota First Nations, Yorkton, Regina Inner City, Fort Qu'Appelle) tested various primary health care service models including: team-based care and LEAN quality improvement tools; extended hours clinics; integrated mental health and addictions services; new approaches to clinic management; and chronic disease management approaches (Abrametz et al. 2016; Government of Saskatchewan 2014).

Two new types of providers were also introduced in 2012: RN case managers (11 in the province) were put in place to improve continuity of care and the coordination of chronic disease management and primary health care counsellors (12 funded by the Ministry but may be additional counsellors operating in the province as some of the former health regions funded these new positions from existing budgets) to provide early screening and brief treatment for mental health care and addictions in the primary health care clinic.

5) What are the main reform models of primary care/primary health care (list & briefly describe)?

Primary Health Care Teams: Currently 96 Primary Health Care Teams comprised of physicians, nurse practitioners, and allied health professionals funded by the Ministry with the aim to improve health care outcomes for patients by providing them with access to the most appropriate care providers. Team composition is determined by a community needs assessment. Prior to 2012, physicians were required to be salaried or paid by a contract arrangement and were not eligible for fee-for-service payment models if they enrolled as part of a Primary Health Team. However, a decision was made to include all physicians who wanted to be part of a primary health team. Now, physicians who are part of these teams can be fee-for-service and the Ministry will help them provide services to their population of patients as part of a team. The majority of physicians in the teams are on contract and are not classified as employees of the health authority. In some cases, independent FFS clinics undergo partnerships with the health region where the health region will provide some services or supports as well. This does, however, make it more difficult to determine the exact number of primary health care teams operating in the province as not all are then directly funded through the Ministry.

Primary Health Care Networks: developed in Regina; networks "integrate all providers along a continuum of services, organizing services around patient needs rather than program or provider boundaries" (Abrametz et al. 2016).

Remote presence technology: a model used in the northern part of the province, using robotic technology. Advanced telemedicine technology allows an expert health care provider (physician, nurse, and/or pharmacist) to be virtually present in the community, focusing on access to pediatric emergency assessments. In four areas in the northern part of the province, if there was a pediatric emergency, patient would have to be airlifted to Prince Albert or Saskatoon every single time. Now, the specialist can use the robot technology to assess patients in their own community. There is a non-portable and portable handheld device with cameras and video which can connect to available medical equipment, such as a stethoscope, EKG and ultrasound. Patients are being able to stay in their own communities to receive the care they need (Hill 2018).

References:

Abrametz, B., Bragg, T., & Kendel, D. (2016). "Optimzing and Integrating Patient-Centred Care. Saskatchewan Advisory Panel on Health System Structure Report." Saskatchewan Advisory Panel.

CBC News (2017, March 28). "Saskatchewan moves to amalgamate health regions into single authority." Saskatchewan. Retrieved from: http://www.cbc.ca/news/canada/saskatchewan/sask-health-region-amalgamation-1.4044992.

Government of Saskatchewan (n.d.). Retrieved from: https://www.saskatchewan.ca/residents/health/understanding-the-health-care-system/saskatchewan-health-regions/health-region-contact-information-and-websites

Government of Saskatchewan (2017, March 31). "Legislation introduced to create provincial health authority." Retrieved from: http://www.saskatchewan.ca/government/news-and-media/2017/march/28/health-authority-act.

Government of Saskatchewan (2016). Annual Report 2015-16. Ministry of Health. Retrieved from: https://www.saskatchewan.ca/government/government-structure/ministries/health/other-reports/annual-report-archive.

Government of Saskatchewan (2014). Annual Report 2013-14. Ministry of Health.

Government of Saskatchewan (2012). "Primary Health: Patient Centred, Community Designed, Team Delivered." Ministry of Health.

Graham, Jennifer. "Saskatchewan to consolidate health regions into one provincial authority." Globe and Mail (Regina), 4 January 2017. Retrieved from: https://beta.theglobeandmail.com/news/national/saskatchewan-to-consolidate-health-regions-into-one-provincial-authority/article33508083/?ref=http://www.theglobeandmail.com&

Hill, A. (16 July 2018). "Remote presence technology improves access to ultrasound in northern Sask." *The Saskatoon Star Phoenix.* Retrieved from: https://thestarphoenix.com/news/local-news/remote-presence-technology-improves-access-to-ultrasound-in-northern-sask.

Wranik, D., Hanrahan, K., Tarrant, F. (2012). "Contractual Arrangements and Remuneration Methods for Interdisciplinary Teams in Primary Health Care in Public Payer Systems." Dalhousie University.

Last-updated: 2018-09-19
Author(s): Shauna Zinnick, Tara Stewart
Validation: Kristin Anderson

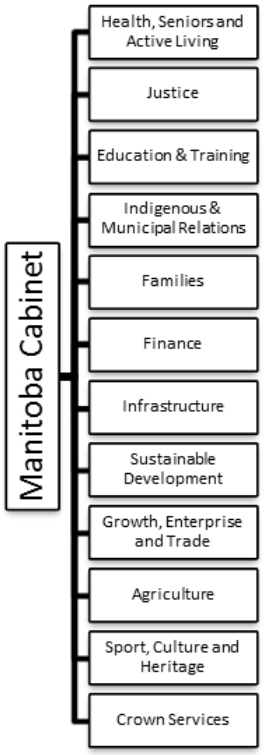
Macro Policy Scan: MANITOBA

Part I: Primary Health Care Policy Structure and Scope

1) What is the formal governance structure for primary care (Ministry name, where in the structure is provincial/territorial oversight for primary care). If possible, include an organizational chart of provincial government department structure, and an organizational chart of the subsidiary branches, departments, or units of the department of health.

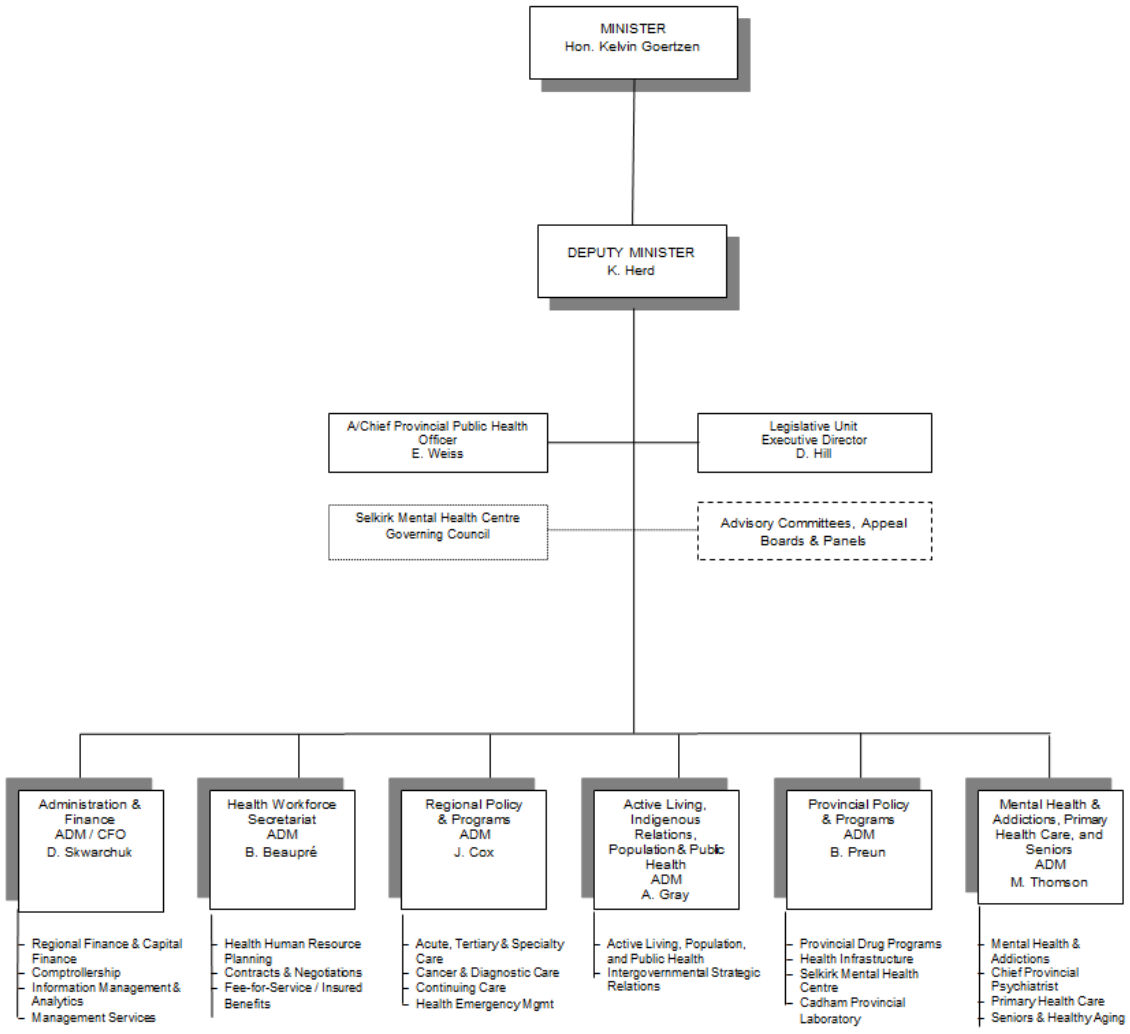
The Manitoba Cabinet is composed of twelve (12) ministries/departments (listed below in Figure 1), one of which is Manitoba Health, Seniors, and Active Living (MHSAL); henceforth referred to as the Department of Health for the purposes of this document.

Figure 1. Manitoba cabinet structure



The Department of Health houses six distinct Divisions, one of which is *Mental Health & Addiction, Primary Health Care, and Seniors*. As such, primary health care shares a level of governance structure with mental health and addictions, the chief provincial psychiatrist, and seniors and healthy aging (see Figure 2).

Figure 2. Manitoba Health, Seniors and Active Living organizational chart



2) What specific services fall under the same governance structure as primary care? (i.e., home care? Social services? End-of-life support? Any public health functions?)

Currently, at the policy level, the following areas fall within the same broad Division as Primary Care: Mental Health & Addictions, Psychiatry, Continuing care and Seniors & Healthy Aging (which was formerly a secretariat until 2016). Public Health falls under a separate Division of MHSAL (Active Living, Indigenous Relations, Population & Public Health). Most social services fall outside the Department of Health and within the Department of Families (employment & income assistance, housing, day care, child protection, etc.).

A provincial primary care strategic plan was developed for the years 2010-2015 and again for years 2016-2020. These strategic plans include the policy perspective, target state and measures that define success for primary care in the province of Manitoba.

3) Is primary care governance and organization decentralized to the regional structures? What are the entities and scopes of responsibility?

Primary health care operations and organization is decentralized to five regional health authorities in Manitoba (Winnipeg, Interlake-Eastern, Southern, Northern, and Prairie Mountain RHAs). The regional health authorities are responsible for the delivery and administration of health services in their respective geographical areas (Manitoba RHA Act; Fransoo et al. 2013). As elsewhere, there are layers of governance of primary care in Manitoba: The primary care branch of Manitoba Health makes recommendations about standards and policies to the Minister of Health – where the decision-making authority ultimately rests. Endorsed standards and policies are then turned back to the primary care branch to implement. The regional health authorities develop and deliver programming to implement the Department of Health priorities. The RHAs submit an annual health plan to the Department of Health and are mandated to complete both a community health assessment and a strategic plan every five years. Additionally, all new RHA initiatives must receive approval and funding from the Department of Health. The regional health authorities provide annually updated regional health plans to the Department of Health.

In July 2017 the MB provincial government announced the formation of a provincial health organization Shared Health Services Manitoba which became operational on April 1, 2018. Shared Health Services Manitoba will allow for "centralized and strategic clinical planning and coordination of the services that should be managed province-wide." Shared Health Services MB will oversee provincial clinical planning and governance (including primary care), provincial health human resources (including physician recruitment and retention), information and communication technology, emergency medical services, provincial laboratory services, provincial diagnostic imaging, provincial procurement, clinical engineering, capital planning, pharmacy services, and a provincial hospital site (the Health Sciences Centre). The five regional health authorities will continue to be responsible for health care delivery and day to day operations and the department of Health, Seniors and Active Living will focus on policy and planning, funding, performance, and accountability (Manitoba Health, Seniors and Active Living 2017).

Another important component of governance of primary care within Manitoba is the organizations that have responsibility for governance in relation to physician and nurse practitioner services. These organizations play a variety of roles. For example, the College of Physicians and Surgeons and College of Registered Nurses are the regulatory bodies; Nurse Practitioners Association of Manitoba and Manitoba College of Family Physicians are professional associations and Doctors Manitoba represents over 3,000 physicians in the province of Manitoba, advocating for their professional, economic, and personal well-being. These organizations regularly collaborate and share their views with the Department of Health, with the Regional Health Authorities, and with Shared Health Services MB.

4) What are the models for delivery of front-line primary care? (e.g., autonomous private delivery, community health centres, regional health authority). What is the approximate proportion and population coverage?

There are multiple delivery models of primary care in Manitoba (reform models are listed in the next section).

Fee-For-Service Clinics (FFS) is the dominant model. The fee-for-service model involves primary care providers who submit claims for each service they provide to an eligible resident of Manitoba based on a pre-determined fee schedule. FFS practitioners provide a range of services that may include both episodic and comprehensive care, as well as extended hours including evenings and weekends. Over 80 percent of primary care services are provided by this model (Katz et al. 2016).

Regional Health Authority-Operated Clinics:

- **Health/Social Service ACCESS Centres** have been launched in urban areas of Manitoba. The model was developed to address the primary health care needs of specific underserved populations. ACCESS centres offer a broad range of services that are tailored to match local needs, such as primary medical care, social services, mental health, home care, employment, and income assistance programs. If a patient requires services that are not offered within the ACCESS centre, they are referred to related community resources that can assist them. The model is provincially funded; primary care providers receive alternative funding or are funding on a seasonal basis. There are seven ACCESS Centres located in Winnipeg (Access Downtown Primary Care Clinic, ACCESS Fort Garry, ACCESS NorWest, ACCESS River East, ACCESS St. Boniface, ACCESS Transcona, and ACCESS Winnipeg West. Some ACCESS centres include a co-located Walk-In Connected Care (WICC) Clinic (an evolution of the Quick Care Clinic Model described in PC reforms section below).
- **Primary Care Centres:** Primary care clinics that consist of various types of providers and services, but are not affiliated, or co-located, with ACCESS centres. A number of Walk-In Connected Care (WICC) Clinics (an evolution of the Quick Care Clinic Model described below) would be classified herein (i.e., the ones that are not co-located with ACCESS centres).
- **Interdisciplinary Teaching Clinics:** There are three interdisciplinary teaching clinics located in Winnipeg. While the initial mandate of these clinics was to provide education and training to family physicians, the clinics have evolved to a point where most of the care provided at the clinics is provided by trainees who are supervised by experienced care providers such as family physicians, nurse practitioners, interdisciplinary teams of nurses, social workers, pharmacists, and nutritionists. The three teaching clinics in Winnipeg are: Family Medical Centre, Kildonan Medical Centre, and Northern Connection Medical Centre. These clinics are funded through different mechanisms because of their mandate for education, with the supervising primary care providers are funded through a mechanism similar to the Community Health Agency clinics and the regionally run primary care clinics.

Community Health Centres: CHCs (also known as Community Health Agency Centres) were established over four decades ago "in response to a national movement that promoted interdisciplinary team-based care to focus on specific groups (e.g., women; Francophones)" (Katz et al. 2016). The clinics have evolved over time and staff and funding is based on the needs of the populations serviced. These clinics are operated by community boards and receive alternative or seasonal funding. There are seven clinics in the Winnipeg health region (Aboriginal Health and Wellness Centre; Centre de Santé Saint Boniface; Hope Centre Health Care Inc.; Klinic Community Health Centre; Mount Carmel Clinic; NorWest Co-Op Community Health Centres; and Women's Health Clinic).

Provincial Nursing Stations (on-reserve): Offer a broad range of primary health care services by an interdisciplinary team of providers in northern and remote communities. Services include screening, prevention, emergency care and treatment services on a 24/7 basis delivered by nurses with full RN scope of practice. Visiting physician services vary by community.

Hybrid Models: Includes clinics that are a combination of FFS and RHA (or CHC) by virtue of the physician payment model and/or the clinic ownership model.
In Winnipeg, the patient distribution by model of primary care is: 93.9% FFS; 2.6% in WRHA ACCESS primary care; 1.9% Community Health Clinic; 1.5% Teaching Clinic (Katz et al. 2016). Community health clinics saw the highest percentage of patients in the lowest income group (and the smallest percentage of patients in the highest income group). WRHA primary care and community health clinics had a higher percentage of patients with each social complexity (e.g., high residential mobility, low-income quintile, social housing resident, income assistance) as compared to other models of primary care. FFS providers saw patients with the lowest percentage of social complexities, except for one (major mental health diagnosis; Katz et al. 2016).

5) What are the main reform models of primary care/primary health care (list & briefly describe)?
The Primary Care Branch of Manitoba Health, Seniors and Active Living oversees several reform models of primary care:

Physician Integrated Network (PIN): has been part of primary care renewal efforts in Manitoba since 2006. Through PIN, Manitoba Health worked with fee-for-service clinics to find ways to improve primary care services by improving access to care; improving primary care providers' access to and use of information; improving the work life of primary care providers; and demonstrating high quality primary care with a focus on chronic disease. PIN was a demonstration initiative and therefore, learnings from each phase (including those derived from patient and physician feedback) were used to inform changes to subsequent initiatives and to inform provincial policy development and broader strategies for improving primary care in Manitoba. For example, learnings from PIN have informed the of the current My Health Teams model (Manitoba's operationalization of the Primary Care Networks/Family Health Teams, see below).

Home Clinics: were launched in November 2016 and are based on the Patient's Medical Home model, which was envisioned/developed by the College of Family Physicians of Canada. This includes registration as a Home Clinic, formal enrolment of patients, and provision of regular data extracts which

are used to monitor Primary Care Quality Indicators and satisfaction of requirements for chronic disease management tariffs. Chronic disease management (CDM) tariffs are billable annually for providing comprehensive chronic disease management to a patient with one or more of the following chronic diseases: diabetes, asthma, Congestive Heart Failure, Coronary Artery Disease, or hypertension. Comprehensive Care Management (CCM) is a tariff added in 2017 and is applicable to enrolled patients and takes account of age and chronic diseases; to claim it, physicians must demonstrate compliance with chronic disease management guidelines.

Interprofessional Team Demonstration Initiative (ITDI): The Manitoba government provided funding and support for the development of inter-professional teams within fee-for-service clinics throughout the province (accountability agreement with FFS clinics and regions). A provider of the FFS clinic's choosing was placed directly into the clinic; his/her salary was paid by the health region. Most ITDI providers were physician assistants or nurses. They provide care to the FFS patient panel, thereby freeing up the FFS provider to increase panel size.

My Health Teams (MyHT): (previously known as Primary Care Networks). Collaborative partnerships between regional health authorities, independent primary care practices, and community organizations who work closely with one another to plan, develop and provide enhanced local primary care services (accountability agreement with FFS clinics and regions). Networked providers share access to an inter-disciplinary provider(s) of the network's choosing – examples include: chronic disease educator, mental health counsellors Income Security Health Promoter (Social Worker), and Occupational Therapists. Access to these additional inter-disciplinary resources mean assistance with patient care and, theoretically, allow a My HT PCP to increase panel size and provide comprehensive care to patients.

Centralized Waiting List: Known as Family Doctor Finder in Manitoba; implemented mid-2013. As of 2016, a family provider was found for over 41,000 Manitobans. The program has helped build a stronger relationship between the Department of Health and FFS primary care providers and has also allowed for targeted prioritizing of patients with more complex needs who may otherwise have a difficult time finding a primary care provider.

Advanced Access: Assistance and training available to help FFS providers design and implement advanced access so that patients can see the FFS provider at a time and date convenient for them.

Quick Care Clinics: Offer episodic care provided by NPs and Registered Nurses (RNs) and offer a wide range of care for minor health issues. Services also include the ordering of diagnostic tests and prescribing medications.

Mobile Clinics: Mobile clinics are buses that have been specifically designed to be primary care clinics and are staffed by NPs and RNs that provide primary care for people living in smaller, underserviced communities that do not have an existing primary care clinic. The clinics on wheels provide the full range of primary care services, such as physical exams, diagnostic tests, immunizations, referrals, and well baby care. Nurse practitioners can order medications and diagnostic tests, refer patients to specialists when needed and perform minor procedures. Registered nurses can assess health status, manage many

health care issues, and work to manage patients' ongoing medical conditions. The first two mobile clinics were developed and implemented within the Prairie Mountain Health region and the Southern Health-Santé Sud region (introduced approximately a year apart) and have collectively seen over 4,300 patients in 2 years. Feedback from patients indicates that these clinics are saving people significant travel time to access primary care, and all have reported being satisfied with the overall quality of the care received. The introduction of mobile primary care in these communities is helping to reshape how the health care system provides care and makes a difference for people living in these types of locations. The model provides an alternative to the challenging process of recruiting/retaining providers to live and work in small communities as the mobile clinic enables providers to live in larger communities and still serve the primary care needs of small and remote communities.

Electronic Medical Record adoption program: The Department of Health reimbursed FFS physician practices up to 70% of eligible implementation costs of adopting one of four Manitoba-Approved EMRs, plus up to two years of eligible operating costs, up to a fixed maximum, funded by Canada Health Infoway. This included a communication and training strategy with specific resource development for fee-for-service clinics as regional sites largely leveraged internal resource teams. In 2012, the target of 1000 applicants representing 70% of eligible providers, including family physicians and NPs was achieved. As of October 2015, the EMR adoption rate was approximately 80% (Manitoba eHealth2018). Certification of EMR products in Manitoba is ongoing to ensure products meet provincial standards. The goal of this process to ensure the EMR products implemented and utilized in the province can support the strategic and operational objectives of Manitoba and all end-users now and in the future (Manitoba eHealth 2018).

In addition to the reform models noted above, there are a number of committees, policy structures, and broader health system initiatives in Manitoba that have facilitated the integration of services. These committees, policies, and initiatives don't necessarily fit the definition of a 'primary care reform strategy' or 'innovative service/program' as they themselves do not provide the service; however, the existence of these committee, policies, and initiatives supports work toward integration (i.e., creation of ACCESS centres; developing My Health Teams, etc.). The following are notable committees, policy structures, and initiatives that have facilitated the integration of services in Manitoba:

- **Winnipeg Integrated Services:** The Winnipeg Regional Health Authority (WRHA) and Manitoba Family Services and Housing (FSH) have worked together on an integration of health and social services. The project is referred to as Winnipeg Integrated Services. The vision of integrated community-based and social services is to provide efficient, effective and holistic services which are person or family focussed and recognize the principles of population health and primary health care. Part of the integration of services has been the creation of ACCESS centres which provide primary care and family services.
- **MB Department of Health Service Coordination Advisory Group:** The duties of the Manitoba Health Service Coordination Advisory Group include reviewing issues, developing options, and providing recommendations in support of:

  - The development of Department structures, processes and policies to support service coordination and continuity of care in the context of MyHTs and the larger system, such as the Service Coordination Framework and Service Coordination Lens.
  - The priority identification process and analysis (of opportunities and barriers) that will inform department action to ensure policies support service coordination for system/providers and continuity of care for patient.
  - Establishing and supporting MyHT as the integrator for all primary care and related program areas.
  - To provide coordinated and efficient responses to issues related to service coordination in health care as they arise.
  - To offer leadership in increasing awareness of service coordination initiatives and structures across the department of health by creating a line of communication between the advisory group and each member's respective branch.
  - To acquire support from regions and MHHLS leadership in developing a SC policy.
- **Primary Health Care Strategic Plan 2016/20:** Developed by the Primary Care Branch of Manitoba Health, this documents the strategy for primary care reform going forward in Manitoba.

Shared Health Services: As described on page 3, Shared Health Services Manitoba is a newly-created provincial organization that will oversee provincial clinical planning and governance (including primary care), provincial health human resources (including physician recruitment and retention), information and communication technology, emergency medical services, provincial laboratory services, provincial diagnostic imaging, provincial procurement, clinical engineering, capital planning, pharmacy services, and a provincial hospital site (the Health Sciences Centre).

References:

Fransoo R, Martens P, The Need to Know Team, Prior H, Burchill C, Koseva I, Bailly A, Allegro E. The 2013 RHA Indicators Atlas. Winnipeg, MB: Manitoba Centre for Health Policy, 2013.

Katz A, Valdivia J, Chateau C, Taylor C, Walld R, McCulloch S, Becker C, Ginter J. A Comparison of Models of Primary Care Delivery in Winnipeg. Winnipeg, MB. Manitoba Centre for Health Policy, Spring 2016.

Manitoba eHealth. Primary Care/Community Information Systems (PCIS) Office. Winnipeg, MB.

Manitoba eHealth, 2018. http://www.manitoba-ehealth.ca/emr-pcis.html.

Manitoba Health, Seniors and Active Living. Achieving a high performing provincial healthcare system. Winnipeg, MB. Government of Manitoba, 2017.

Manitoba Laws: The Regional Health Authority Act. Accessed May 16, 2018 from: http://web2.gov.mb.ca/laws/statutes/ccsm/r034e.php#23

Last-updated: 2018-09-19
Author(s): Shauna Zinnick, Tara Stewart
Validation: Kristin Anderson

Winnipeg Regional Health Authority (n.d.). Winnipeg Integrated Services. Accessed August 29, 2017 from: http://www.wrha.mb.ca/community/wis/index.php.

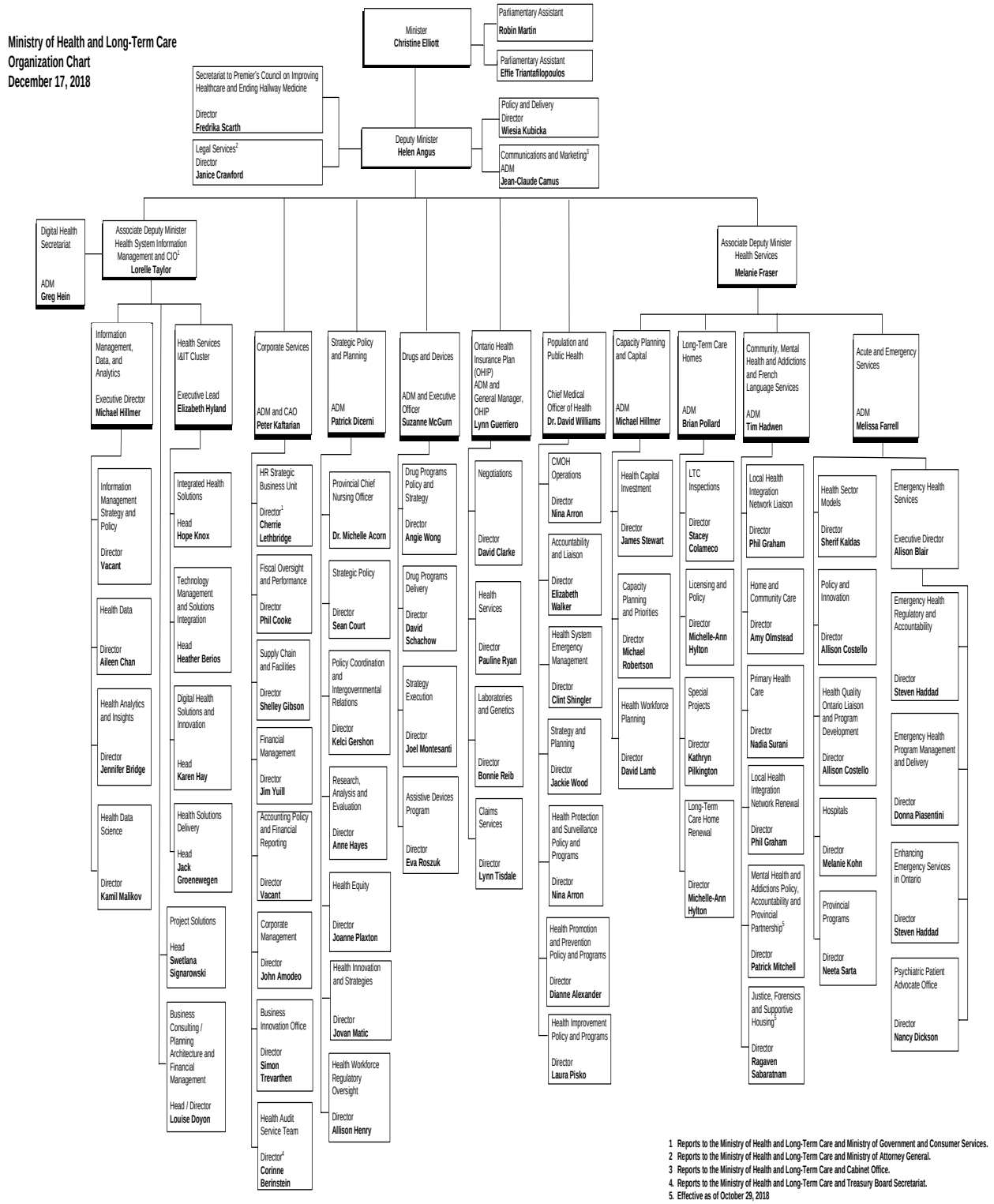
Last-updated: 2019-01-03
Author(s): Noushon Farmanara
Validation (2018-06-26): Ruta Valaitis, Phil Graham (MOHTLC), Brian Hutchison

Macro Policy Scan: ONTARIO

Part I: Primary Health Care Policy Structure and Scope

1) What is the formal governance structure for primary care (Ministry name, where in the structure is provincial/territorial oversight for primary care). If possible, include an organizational chart of provincial government department structure, and an organizational chart of the subsidiary branches, departments, or units of the department of health.

- The Ministry of Health and Long-term Care (MOHLTC) provides the overall direction/leadership for the healthcare system in Ontario.
- As of October 18th, 2018, the MOHLTC underwent a number of structural changes. Reported rationale for some of the structural changes included:
    - Aligning acute and emergency services, bringing hospitals, provincial programs and emergency services together;
    - Bringing together community and mental health and addictions services, including integrating youth mental health services; and,
    - Centralizing the responsibilities for LHIN-managed health services (Dhanraj 2018).
- Notable changes included the combined direction of four divisions: 1) Acute and Emergency Services; 2) Capacity Planning and Capital; 3) Community Mental Health and Addictions and French Language Services; and 4) Long-Term Care Homes, under the Associate Deputy Minister for Health Services (formerly Delivery and Implementation; Figure 2).
    - Within the MOHLTC, the Community, Mental Health and Addictions, and French Language Services Division provides direction and oversight for the Local Health Integration Networks (LHINs), the inter-professional primary care sector, the home and community care sector, and other health services providers (Government of Ontario, n.d.).
    - Under the recent changes, the MOHLTC worked with the Ministry of Children, Community, and Social Services (MCCSS) to identify mental health programs to be transferred to the MOHLTC. A number of mental health related directorates both within the MOHLTC and the MCCSS have now been combined under Health Services, within the Community, Mental Health and Addictions, and French Language Services Division (Dhanraj 2018).
- Under the Acute and Emergency services division is Health Quality Ontario, which is the agency mandated to advise government and health care providers in monitoring and reporting on health care quality in Ontario, supporting improvement of health care, and to support health care policy and programs by formulating recommendations based on the best available evidence (Ministry of Health and Long-Term Care, n.d.).
- **Figure 2. Organizational Chart for MOHLTC (as of December 17, 2018)**


Ministry of Health and Long-Term Care
Organization Chart
December 17, 2018
Minister
Christine Elliott
Parliamentary Assistant
Robin Martin
Parliamentary Assistant
Effie Triantafilopoulos
Secretariat to Premier's Council on Improving Healthcare and Ending Hallway Medicine
Director
Fredrika Scarth
Legal Services[2]
Director
Janice Crawford
Deputy Minister
Helen Angus
Policy and Delivery
Director
Wiesia Kubicka
Communications and Marketing[3]
ADM
Jean-Claude Camus
Digital Health Secretariat
ADM
Greg Hein
Associate Deputy Minister Health System Information Management and CIO[2]
Lorelle Taylor
Associate Deputy Minister Health Services
Melanie Fraser
Information Management, Data, and Analytics
Executive Director
Michael Hillmer
Health Services I&IT Cluster
Executive Lead
Elizabeth Hyland
Corporate Services
ADM and CAO
Peter Kaftarian
Strategic Policy and Planning
ADM
Patrick Dicerni
Drugs and Devices
ADM and Executive Officer
Suzanne McGurn
Ontario Health Insurance Plan (OHIP)
ADM and General Manager, OHIP
Lynn Guerriero
Population and Public Health
Chief Medical Officer of Health
Dr. David Williams
Capacity Planning and Capital
ADM
Michael Hillmer
Long-Term Care Homes
ADM
Brian Pollard
Community, Mental Health and Addictions and French Language Services
ADM
Tim Hadwen
Acute and Emergency Services
ADM
Melissa Farrell
Information Management Strategy and Policy
Director
Vacant
Health Data
Director
Aileen Chan
Health Analytics and Insights
Director
Jennifer Bridge
Health Data Science
Director
Kamil Malikov
Integrated Health Solutions
Head
Hope Knox
Technology Management and Solutions Integration
Head
Heather Berios
Digital Health Solutions and Innovation
Head
Karen Hay
Health Solutions Delivery
Head
Jack Groenewegen
Project Solutions
Head
Swetlana Signarowski
Business Consulting / Planning Architecture and Financial Management
Head / Director
Louise Doyon
HR Strategic Business Unit
Director[1]
Cherrie Lethbridge
Fiscal Oversight and Performance
Director
Phil Cooke
Supply Chain and Facilities
Director
Shelley Gibson
Financial Management
Director
Jim Yuill
Accounting Policy and Financial Reporting
Director
Vacant
Corporate Management
Director
John Amodeo
Business Innovation Office
Director
Simon Trevarthen
Health Audit Service Team
Director[4]
Corinne Berinstein
Provincial Chief Nursing Officer
Dr. Michelle Acorn
Strategic Policy
Director
Sean Court
Policy Coordination and Intergovernmental Relations
Director
Kelci Gershon
Research, Analysis and Evaluation
Director
Anne Hayes
Health Equity
Director
Joanne Plaxton
Health Innovation and Strategies
Director
Jovan Matic
Health Workforce Regulatory Oversight
Director
Allison Henry
Drug Programs Policy and Strategy
Director
Angie Wong
Drug Programs Delivery
Director
David Schachow
Strategy Execution
Director
Joel Montesanti
Assistive Devices Program
Director
Eva Roszuk
Negotiations
Director
David Clarke
Health Services
Director
Pauline Ryan
Laboratories and Genetics
Director
Bonnie Reib
Claims Services
Director
Lynn Tisdale
CMOH Operations
Director
Nina Arron
Accountability and Liaison
Director
Elizabeth Walker
Health System Emergency Management
Director
Clint Shingler
Strategy and Planning
Director
Jackie Wood
Health Protection and Surveillance Policy and Programs
Director
Nina Arron
Health Promotion and Prevention Policy and Programs
Director
Dianne Alexander
Health Improvement Policy and Programs
Director
Laura Pisko
Health Capital Investment
Director
James Stewart
Capacity Planning and Priorities
Director
Michael Robertson
Health Workforce Planning
Director
David Lamb
LTC Inspections
Director
Stacey Colameco
Licensing and Policy
Director
Michelle-Ann Hylton
Special Projects
Director
Kathryn Pilkington
Long-Term Care Home Renewal
Director
Michelle-Ann Hylton
Local Health Integration Network Liaison
Director
Phil Graham
Home and Community Care
Director
Amy Olmstead
Primary Health Care
Director
Nadia Surani
Local Health Integration Network Renewal
Director
Phil Graham
Mental Health and Addictions Policy, Accountability and Provincial Partnership[5]
Director
Patrick Mitchell
Justice, Forensics and Supportive Housing[3]
Director
Ragaven Sabaratnam
Health Sector Models
Director
Sherif Kaldas
Policy and Innovation
Director
Allison Costello
Health Quality Ontario Liaison and Program Development
Director
Allison Costello
Hospitals
Director
Melanie Kohn
Provincial Programs
Director
Neeta Sarta
Emergency Health Services
Executive Director
Alison Blair
Emergency Health Regulatory and Accountability
Director
Steven Haddad
Emergency Health Program Management and Delivery
Director
Donna Piasentini
Enhancing Emergency Services in Ontario
Director
Steven Haddad
Psychiatric Patient Advocate Office
Director
Nancy Dickson
1 Reports to the Ministry of Health and Long-Term Care and Ministry of Government and Consumer Services.
2 Reports to the Ministry of Health and Long-Term Care and Ministry of Attorney General.
3 Reports to the Ministry of Health and Long-Term Care and Cabinet Office.
4. Reports to the Ministry of Health and Long-Term Care and Treasury Board Secretariat.
5. Effective as of October 29, 2018

2) What specific services fall under the same governance structure as primary care? (i.e., scope – home care? Social services? End-of-life support? Any public health functions?)

- The MOHLTC establishes the overall strategic direction and provincial priorities for the health system (Ministry of Health and Long-Term Care [MOHLTC], 2017a).
    - Both primary care and elements of primary health care are a shared responsibility within the MOHLTC. Responsibilities are distributed amongst multiple divisions within the ministry.
        - Example: negotiations over physician services (a significant aspect of primary care), digital health enablers, and oversight of interprofessional models reside within separate divisions (see figure 2). Collaboration structures to facilitate alignment of this sector across the ministry (Personal communication, MOHLTC, June 6, 2018). However, it was beyond the scope of this scan to capture these structures.
    - The Community, Mental Health and Addictions and French Language Services division also provides oversight for five additional areas (see figure 2) including for the Local Health Integration Networks (LHINs), the home and community care sector, and other health service providers.
- Governance of social services generally does not fall under the same governance structure as primary care. The Ministry of Community and Social Services (MCSS) is responsible for social services including welfare, the Ontario Disability Support Program, and other community service programs (Ministry of Community and Social Services [MCSS], 2016).
- Although most health services fall under the same governance structure (i.e., Ministry) as primary care, services for particular populations (such as children and youth with special needs – which is the responsibility of the Ministry of Children and Youth Services) may not. However, there appears to be cross-ministry coordination.
- With that, primary care in Ontario remains quite centralized relative to other health services (e.g., hospitals, home care, community support services, etc.) which are overseen or delivered by LHINs.
- Overall governance of public health does fall under the MOHLTC. Regional governance of public health differs from primary medical care. Under the Patients First Act, funding and accountability oversight of public health units were not transferred to the LHINs; although, the act did mandate that formal linkages between public health and LHINs should be instituted for better population health planning.
    - The Population and Public Health Division of the MOHLTC is mandated to: conduct surveillance; implement strategies to ensure continuity of critical ministry services during an emergency; ensure appropriate actions are taken to respond to urgent and/or emergency situations; designing, implementing, funding and monitoring public health

programs; inform and advise other provincial partners on evidence-based human health impacts of government initiatives; advance public health in Ontario by providing and supporting education, research, training, and resource tools.

3) Is primary medical care governance and organization decentralized to the regional structures? What are the entities and scopes of responsibility?

- Yes. Local Health Integration Networks (LHINs) are Crown Agencies responsible for planning, funding, and delivering, local health care to 14 geographic areas in the province (Fig. 3).
    - The LHINs differ in their size, population health profile, service delivery capacity and health services providers. Each LHIN is governed by a board of directors and the chair is accountable to the MOHLTC for goals, objectives, and performance of the network. Board members are appointed by the Lieutenant Governor of Council with the advice of the Cabinet. Each LHIN has a CEO who is responsible for management of the organization and its staff (Office of the Auditor General of Ontario 2015).

Figure 3. Map of LHIN regions in Ontario

1. Erie St. Clair
2. South West
3. Waterloo Wellington
4. Hamilton Niagara Haldimand Brant
5. Central West
6. Mississauga Halton
7. Toronto Central
8. Central
9. Central East
10. South East
11. Champlain
12. North Simcoe Muskoka
13. North East
14. North West

- LHINs are responsible for planning and funding of hospitals, long-term care homes, community services, and mental health and addiction services. Under the Patients First Act, the LHINs were given the additional responsibility of home care delivery (which was previously under the function of Ontario's 14 Community Care Access Centres), as well as primary care. The delivery responsibility for home care is an important distinction, as this is different from the other functions that LHINs perform.

    - Note: responsibility for primary care is limited to local planning and authority to fund (non-physician) interprofessional primary care teams. LHINs are prohibited from funding physicians directly, as this role is retained by the province.
- Restructuring/reforms put forward through the Patient's First Act (2015/16) to expand the scope of coordination/governance of LIHNs and to better integrate primary care with other community-based services.
    - Part of this restructuring includes establishing smaller geographical planning regions (sub-LHINs) within each LHIN to help address patient needs at the local level and better respond to community needs within the local health system.
    - The Patient's First Act also aims to increase accountability by giving LHINs the authority to investigate/supervise health services providers and to negotiate service accountability agreements with providers (MOHLTC 2016a). As part of the commitment to improved and expanded patient engagement put forward in the new legislation, Ontario also initiated the creation of a Patient and Family Advisory Council (MOHLTC 2016b). This council facilitates involvement of patients, families, and caregivers in the policy development process.
- Each health care organization has its own Board of Directors. Boards are responsible for strategic planning, financial oversight, management performance, and ensuring quality of care.
- Health Quality Ontario also provides quality indicators for primary care performance. It reports to the public, organizations, government, and health care providers on how the health system is performing, and identifies strong practices based on best available evidence to inform clinical standards and recommendations to health care professionals and funders (Health Quality Ontario, n.d.).

4) What are the main models for delivery of front line primary medical care? (e.g., autonomous private delivery, reform models by name, community health centres) What is the approximate proportion and population coverage?

- Key policy initiatives in Ontario since 2000:
    - Introduced new physician reimbursement and organizational models that supported/incentivized patient enrolment with a primary care provider.
    - New primary care models (for the most part) required that physicians participate in group practices/networks of three or more physicians, which reduced the proportion of physicians who identified as 'solo practitioners'.
        - Some models included the requirement of providing a minimum number of weekend and/or evening office hours; this varied by size of the practice. Other than these, new models supported but didn't require changes in organization and delivery of care.

  - Resulted in the initiation of a number of new primary care organizational models between 2002 and 2007 with an emphasis on group- and/or team-based primary care and shifting reimbursement schemes away from a predominantly FFS model.

Walk-in clinics: walk-in clinics provide medical care for individuals who do not have a family doctor or have one and are unable to reach them (Government of Ontario 2017); although, use of walk-in clinics is not encouraged.

Solo-practice (Fee-for-Service): Up until the early 2000s, primary medical care was delivered primarily through solo or small group practices (owned and managed by physicians).

- Physicians are reimbursed primarily on a fee-for-service (FFS) basis.
- **Comprehensive Care Model (CCM)**
  - Established in 2005, the CCM was introduced to encourage solo practitioners to enroll patients in the practice and provide some afterhours care (although after hours care is not required). There are financial incentives tied to these services (Marchildon and Hutchison 2016).

Independent Group Practices (not inter-professional): Reforms and primary medical care organizational models that encourage group practice, formation of primary care networks, and/or increased patient enrolment – particularly for select patient groups (Hutchison et al. 2011).

- These models, introduced between 2001 and 2007, were all based on key elements such as patient enrolment, minimum group/practice sizes, and variations in reimbursement schemes (i.e., combinations of fee-for-services, capitation, pay-for-performance, and salary).
- Although these reflect primary care *funding* models – they have influenced the organizational structure of the primary care organization to some extent based on the required characteristics to be eligible for funding.
- **Family Health Network (FHN;** Glazier et al. 2012; Hutchison et al. 2011; McLeod et al. 2016**)**
  - Introduced in Ontario in 2001 and required practice to have 3 or more physicians providing care.
  - Required formal rostering of patients (i.e., enrolment); loss of access bonus payments if patients receive primary care outside of their rostering group.
  - Clinics must provide some evening and weekend services with an on call '24/7' physician and teletriage nurse support. Incentives were provided if patients were seen after normal working hours, for chronic disease management, and for achieving cumulative practice thresholds for certain preventive care services.
  - Primary medical care model based on capitation reimbursement of physicians, blended with limited fee-for-service (FFS) payments and incentives. Capitation payments based on expected number of office visits for a particular five-year age-sex group – these were not adjusted for health care needs or social disparities. A monthly payment ("comprehensive care free") is also paid per patient registered in the network. Most visits are paid at approximately 10% of the full FFS value.

    - Approximately 1.8% (232 physicians) work under this model (Marchildon and Hutchison 2016).
- **Family Health Group (FHG)**
    - Model introduced in 2003. Similar requirements as the FHN (must have 3 or more practicing physicians as well as provide some after-hours coverage through either direct or telephone-based services).
    - However, payment is predominantly FFS-based with an additional comprehensive care fee per patient (Marchildon and Hutchison 2016).
    - Approximately 20.5% (2670) of physicians practice under this model.
- **Family Health Organization (FHO)**
    - Established in 2007, the FHO had similar provisions as the FHN but for a broader basket of primary care services and with a larger capitation payment.
    - Approximately 40.2% (5161) of physicians practice under this model (Marchildon and Hutchison 2016).

Team-based models of care (inter-professional): "groups of professionals from different disciplines who communicate and work together in a formal arrangement to care for a patient population in a primary care setting" (Hutchison and Glazier 2013).

- **Community Health Centres (CHC)**
    - Established in 1979, CHC are distinct from other primary care models in that they focus on the needs of specific populations; in particular, socially disadvantaged, and harder-to-serve populations.
        - Examples: groups that experience difficulties accessing primary care due to language barriers, cultural barriers, physical disabilities, homelessness, poverty, or living in remote areas.
    - Unlike other primary medical care models, CHC are more oriented to include outreach and health promotion - providing health care as well as health promotion services and are governed by community boards.
    - 75 CHCs service approximately 500,000 people with 250,000 accessing primary care services. Employ ~400 primary care physicians and 300+ nurse practitioners with salaried payment schemes. (Hutchison and Glazier 2013)
- **Family Heath Teams**
    - In 2006, Family Health Teams (FHTs) were introduced, with characteristics of the patient-centered medical home, as described by the College of Family Physicians of Canada (College of Family Physicians of Canada 2011). Patients access care from multiple health care providers in the same setting (e.g., nurses, NPs, dieticians, mental health workers, social workers, pharmacists, health educations, occupational therapists, etc.)
    - FHTs require that physicians be paid through either one of the blended capitation models (FHNs or FHOs) or a blended salary model. Fee-for-service physicians and those in FHGs were not eligible to belong to an FHT. All other care providers are salaried. (Ministry of Health and Long-Term Care 2017b)
    - Approximately 2771 (22.1%) of physicians are affiliated with this model (Marchildon and Hutchison 2016).

- **Nurse Practitioner-led Clinics**: similar to FHTs but physicians act primarily in a more consulting role.
    - Teams led by (salaried) Nurse Practitioners and consisting of RNs, RPNs, collaborating physicians, and other interdisciplinary health providers (IHP) to provide comprehensive primary care services to unattached patients (i.e., those who did not have access to a primary care provider).
    - All 25 NPLCs in Ontario are not-for-profit organizations, with governance through a board of directors (some of which are community led).
    - NP/IHP salaries, and operational funding put forward through agreement between the nurse practitioner-led clinic and the MOHTLC.
    - Services delivered through NPLCs include comprehensive primary health care; health promotion and disease prevention; chronic disease management; support for patients with mental illness; care coordination and navigation through the healthcare system; and integrated care through established partnerships in the community (Association of Ontario Health Centres [AOHC], n.d.).
- **Aboriginal Health Access Centres (AHAC) and Aboriginal Community Health Centres (Aboriginal CHC):** centres provide community-directed health programs and services for First Nations and other Aboriginal peoples.
    - Stemmed from the Aboriginal Health and Wellness Strategy (AHWS) initiated in Ontario in 1994. One of the pillars of the AHWS was the creation of Aboriginal Health Access Centres to provide culturally appropriate and relevant health care (AOHC 2015). Centres were initiated beginning in 1995 and were modelled after Ontario's CHCs.
    - Care provided to First Nations, Inuit, and Métis communities is unique and follows an Indigenous, holistic health and wellness model – these encompass mental, physical, emotional, and spiritual care. Services are provided by health and social services professionals as well as traditional healers.
    - Services provided in AHACs include primary medical care, traditional health, mental wellness, cultural programs, health promotion programs, community development initiatives and social support services.
        - **Traditional healing services:** storytelling; ceremonies (e.g., seasonal, rites of passage, healing, sweat lodges); feasts; traditional arts and crafts; drumming; dancing; traditional teachings; circles; traditional medicines (e.g., doctoring, counselling, medicine walks).
        - **Community Programs:** mental wellness; trauma-based therapies; seniors' physical activity; addressing seniors' social isolation; childhood physical activity; childhood nutrition; early childhood development; housing; food security; harm reduction; homelessness; community kitchens; rehabilitation services, etc.
        - **Primary care:** primarily, clients accessing primary care services in AHACs are seeking care for Diabetes (type II), mental health, hypertension, and well

care. Most AHACs also provide home and community visit for primary care, which typically service: frail seniors; those requiring palliative/end-of-life care; those with mental health issues; clients with disabilities; and isolated/remote patients (AOHC 2015).

- Currently, there are 10 AHACs operating in Ontario as well as 3 Aboriginal CHCs, 1 Aboriginal NPLC, and 5Aboriginal FHTs.
- The MOHLTC and LHINs invest approximately $45 million in these Aboriginal-focused primary care centres and models (AHAC & Aboriginal CHC 2016). On average, base funding for an AHAC is approximately $3 million.

Recent investments have also been made in both Indigenous governed interprofessional primary care teams and mainstream interprofessional primary care. These investments are expected to involve partnerships with other health care organizations, municipalities, and social services, etc. (Personal communication, MOHLTC, June 6, 2018).

Other: sexual health clinics offer a variety of free and confidential clinical services. These clinics may be stand-alone, in Public Health Units, in Community Health Centres, or on college and university campuses (Government of Ontario 2015).

Approximately 75%[2] of Ontario's population is covered under new reform models (Hutchison & Glazier 2013)

- Under reform models, patients are not required to enroll (even if their regular physician participates in one of the models and does offer enrolment). Agreeing to enroll requires patient to seek treatment first from the enrolled physician or group practice. With patient enrolment as an integral feature of these reforms, patient enrolment with a primary care provider in Ontario grew from 600,000 in 2002 to 9.5 million in 2010 (Hutchison et al. 2011).
- **Health Care Connect:** initiative to link 'unattached' patients to a primary care provider:
  - Help those without provider obtain a regular one with the assistance of a nurse 'care connector' (identifies providers willing to accept patients). Priority focus: **high-needs** patients – physicians who accept high-needs patients receive a bonus for enrolment and for the first year of care.
- Estimated that 92.5% of Ontarians have a regular doctor (self-report), according to data from CCHS (Statistics Canada 2014). According to the MOHLTC, approximately 94% of Ontarians have a family doctor or other primary care provider (MOHLTC 2017c).

[2] Article cites a personal communication with Ministry of Health and Long-Term Care from 2012.

Last-updated: 2019-01-03
Author(s): Noushon Farmanara
Validation (2018-06-26): Ruta Valaitis, Phil Graham (MOHTLC), Brian Hutchison

References:

Association of Ontario Health Centres. (n.d.). Nurse practitioner-led clinics. Retrieved from: https://www.aohc.org/nurse-practitioner-led-clinics.

Association of Ontario Health Centres. (2015). 2015 Aboriginal health access centres report. Retrieved from: https://www.aohc.org/sites/default/files/documents/2015%20AHAC%20Report%20-%20Copy.pdf.

College of Family Physicians of Ontario. (2011). A vision for Canada: Family practice – the patient's medical home. Retrieved from: https://www.cfpc.ca/uploadedFiles/Resources/Resource_Items/PMH_A_Vision_for_Canada.pdf.
Dhanraj, T. (2018). Government memo indicates major restructuring plan for Ontario Ministry of Health. Global News, October 19, 2018. Retrieved from: https://globalnews.ca/news/4571032/government-memo-restructuring-ontario-ministry-of-health/.

Glazier RH, Zagorski BM, Rayner J. Comparison of Primary Care Models in Ontario by Demographics, Case Mix and Emergency Department Use, 2008/09 to 2009/10. ICES Investigative Report. Toronto: Institute for Clinical Evaluative Sciences; 2012.

Government of Ontario. (n.d.). Employee and organization directory, Health and Long-Term Care. Retrieved from: http://www.infogo.gov.on.ca/infogo/home.html#orgProfile/3964/en.

Government of Ontario. (2017). Walk-in clinics. Retrieved from: https://www.ontario.ca/page/walk-clinics.

Government of Ontario. (2015). Sexual health clinics. Retrieved from: https://www.ontario.ca/page/sexual-health-clinics.

Health Force Ontario. (2017). Family medicine compensation and practice models in Ontario. Retrieved from: http://www.healthforceontario.ca/UserFiles/file/PracticeOntario/FM%20Compensation%20Practice%20Models%20EN.pdf.

Health Quality Ontario. (n.d.). Who we are. Retrieved from: https://www.hqontario.ca/About-Us/Who-We-Are.

Hutchison, B., Levesque, J. F., Strumpf, E., & Coyle, N. (2011). Primary health care in Canada: systems in motion. *The Milbank Quarterly*, *89*(2), 256-288.

Hutchison, B., & Glazier, R. (2013). Ontario's primary care reforms have transformed the local care landscape, but a plan is needed for ongoing improvement. *Health affairs*, *32*(4), 695-703.

Laupacis, A. (2014). A primary on Ontario's health care system for primary health care boards of directors. Healthy debate. Retrieved from: http://www.lhincollaborative.ca/serviceaccountabilityagreements.aspx.

Local Health Integration Networks Collaborative. (2014). Service accountability agreements. Retrieved from: http://www.lhincollaborative.ca/serviceaccountabilityagreements.aspx.

Marchildon, G. P., & Hutchison, B. (2016). Primary care in Ontario, Canada: New proposals after 15 years of reform.*Health Policy*, *120*(7), 732-738.

McLeod, L., Buckley, G., & Sweetman, A. (2016). Ontario primary care models: a descriptive study. *CMAJ open*, *4*(4), E679.

Ministry of Community and Social Services. (2016). About the ministry: Our programs and services. Retrieved from: https://www.mcss.gov.on.ca/en/mcss/about/.

Ministry of Health and Long-Term Care. (n.d.). Health Quality Ontario. Retrieved from: http://www.health.gov.on.ca/en/pro/programs/ecfa/legislation/hqo.aspx.

Ministry of Health and Long-Term Care. 2016. The Patients First Act: Backgrounder. Retrieved from: https://news.ontario.ca/mohltc/en/2016/12/the-patients-first-act.html.

Ministry of Health and Long-Term Care. (2016). Ontario establishing patient and family advisory council. News release. Retrieved from: https://news.ontario.ca/mohltc/en/2016/10/ontario-establishing-patient-and-family-advisory-council.html?_ga=2.202673109.5367880.1523455676-785412499.1502721657.

Ministry of Health and Long-Term Care. (2017a). About the ministry. Retrieved from: http://www.health.gov.on.ca/en/common/ministry/default.aspx.

Ministry of Health and Long-Term Care. (2017b). Primary care payment models in Ontario. Retrieved from: http://www.health.gov.on.ca/en/pro/programs/pcpm/.

Ministry of Health and Long-Term Care. (2017c). Patient's first action plan for health care: Year two results. Retrieved from: http://www.health.gov.on.ca/en/ms/ecfa/healthy_change/docs/year_two_results_action_plan_en.pdf.

Mukhi, S., Barnsley, J., & Deber, R. B. (2014). Accountability and primary healthcare. *Healthcare Policy*, *10*(SP), 90.

Office of the Auditor General of Ontario. 2015. Annual report 2015. Retrieved from: http://www.auditor.on.ca/en/content/annualreports/arreports/en15/2015AR_en_final.pdf.

Last-updated: 2019-01-03
Author(s): Noushon Farmanara
Validation (2018-06-26): Ruta Valaitis, Phil Graham (MOHTLC), Brian Hutchison

Ontario Aboriginal Health Access Centres & Aboriginal Community Health Centres. (2016). Report to communities. Retrieved from: https://www.aohc.org/sites/default/files/documents/AHAC_Aboriginal_CHC_Report_2016.pdf.

Last updated: 2018-05-22
Authors: Catherine Labasi-Samartino, Amélie Quesnel-Vallée
Validation: Mylaine Breton

MACRO POLICY SCAN: QUÉBEC

Part I: Primary Health Care Policy Structure and Scope

1) What is the formal governance structure for primary care (Ministry name, where in the structure is provincial/territorial oversight for primary medical care)? If possible, include an organizational chart of provincial government department structure, and an organizational chart of the subsidiary branches, departments, or units of the department of health.

- Quebec's health system is public. The state is both the main insurer and administrator.
- The Ministry of Health and Social Services Center (MSSS) is the governance structure overseeing the delivery of care by the 13 Integrated health and social services centers (CISSS) and nine Integrated University health and social services centers (CIUSSS). These centers are distributed across territorial health and social services networks (RTS). The regional authorities were abolished in 2015 (CCNPPS).
- Primary medical care governance:
    - Primary medical care falls under the purview of the Deputy Directors of first line integrated services [*Direction générale adjointe des services de proximité intégré*], who report to the Associate Deputy Minister of first line, emergency and prehospital services [*Direction générale des services de proximité, des urgences et du préhospitalier (DGSPUP)*]. This ADM reports to the Deputy Minister of Health and Social Services, who reports to the Minister of Health and Social Services (see figure 1).
    - The d*épartement regional de médicine générale* (DRMG) is the body that brings together all general practitioners in a particular health region and falls under the purview of the regional health authorities (Levesque et al. 2012). DRMGs exist in every health and social service region, with the mandate to support organization of PHC in the respective territories, to make recommendations regarding human resources planning, and to generate a list of *activités médicales paticulières* (AMP; Levesque et al. 2012; Le Commissaire á la santé et au bien-être 2009).

      Ensuring the quality of primary health care services is primarily under the responsibility of the provincial colleges of physicians and surgeons. Medical practices have thus mostly been left to professional logic guidance in both their development and their governance (Pineault et al. 2009). However, the organizational reform enacted under Bill 10 (Quesnel-Vallée and Carter 2018) and the subsequent omnibus reform of Bill 20 seek to increase accountability of all health providers in the system, including primary care physician providers.
        - Physicians are represented by two unions in Quebec: the Fédération des médecins omnipracticiens du Québec (FMOQ), representing general practitioners, and the Fédération des médecins spécialistes du Québec (FMSQ), representing specialists (QMA 2015).

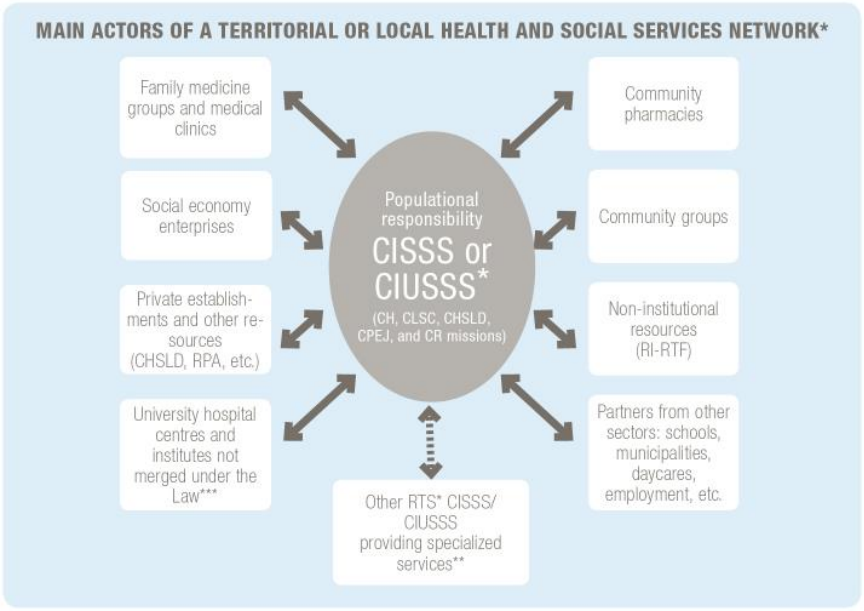
2) What specific services fall under the same governance structure as primary care? (i.e., scope – home care? Social services? End-of-life support? Any public health functions?)

- May 2018: organizational chart of the MSSSQ now put primary care and emergency services under the same ADM, separate from other hospital and physician specialist services (note: nursing services are under the latter ADM portfolio, not under primary care).
- Primary health care reforms in Quebec have drawn heavily from this definition: includes basic social and medical health services which aim to solve most of the population's common preoccupations and problems (Commission d'étude sur les services de santé et les services sociaux 2000).
    - Nursing services
    - General medical services
    - Psychological or social counseling services
    - Rehabilitation services
    - Home care support services
    - Telephone intervention services (Info-Santé)

3) Is primary care governance and organization decentralized to the regional structures? What are the entities and scopes of responsibility?

- Territorial integration of health and social services is ensured through area networks (*Réseau territorial de services*; RTS) designed to provide proximity and continuity of services.
- Integrated health and social services centers (*Centres intégrés de santé et de services sociaux*; CISSS) or integrated university health and social services (*Centres intégrés universitaires de santé et de services sociaux;* CIUSSS) are responsible for managing and delivering services within their jurisdiction.
- In every RTS, the CIUSSS ensure the "development and proper functioning of all local health (including mental health) and social service networkers that operate within its territorial service network to fulfill their population-based responsibility" (Pineault et al. 2016).
    - Each CIUSSS develops collaborations and partnerships with primary health care clinics, community groups and pharmacies, non-merged hospitals and other partners (e.g., schools).
    - These networks share the responsibility of providing integrated services that coincide with the needs of the population they serve, based on service agreements with the MSSS.
        - To do so, they are required to deliver comprehensive treatment and services in proximity of their client's living location.
        - Also required to provide proper care and follow-up of their clients within the health and social services system.
    - Before the CIUSSS reform, centres de santé et services sociaux (CSSS) existed as result of an administrative fusion of shelters and long-term care centers (CHSLD), CLSCs, and sometimes a hospital center (CH). Their mandate was to create a network of local services (RLS). The latest CIUSSS reform is essentially a merger of these types of fusions accompanied by the abolition of a layer of administrative structures (Quesnel-Vallée and Carter 2018).

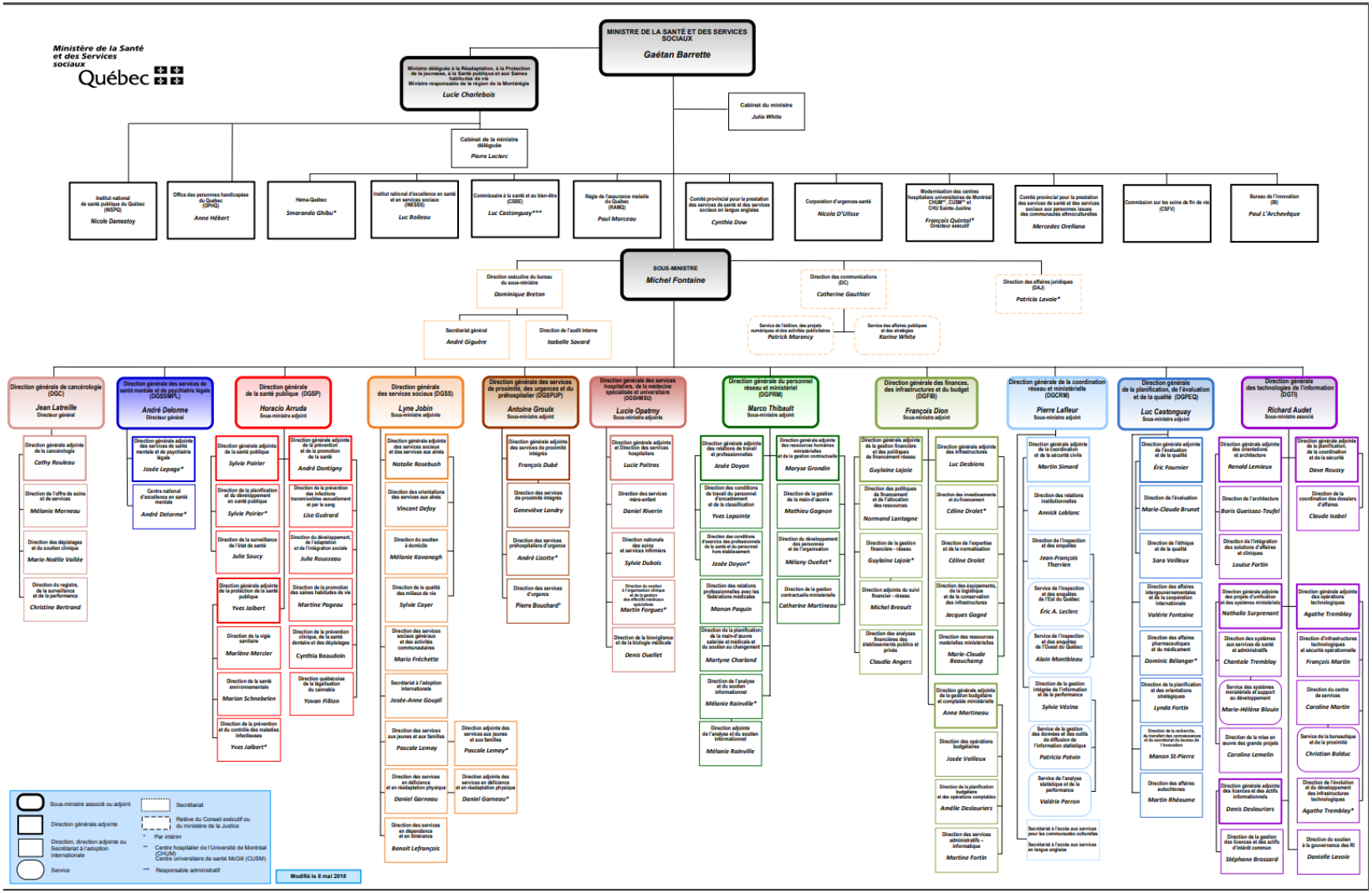
- CISSS and CIUSSS have the mandate to coordinate services provided by all partners in the network, namely:
    - Medical clinics and family medicine groups (GMF/FMG). FMG is the predominant model of PHC based on interdisciplinary teams to enroll population. Currently, more than 300 FMG provide care within the province. In 2011, 223 FMG covered approximately 25% of the population (Breton et al. 2011);
    - community-based pharmacies;
    - community organizations;
    - social economy enterprises;
    - private establishments and other resources such as residential and long-term care centers (CHSLD) or private residences for seniors (RPA);
    - non-institutional intermediate and family-type resources;
    - unamalgamated university hospital centers and institutes that provide specialized or highly specialized services to the population;
    - if applicable, other integrated centers with supra regional mandates that provide specialized or highly specialized services to patients in the service network may be added in compliance with established service corridors, such as a hospital center, a child and youth protection center or a rehab center; and
    - partners from other sectors: schools, municipalities, employment, etc.



* Any given RTS may include more than one RLS that uses identical categories and partners at the local level.
** The CISSS or CIUSSS must establish, if necessary, regional or interregional service corridors in order to complete the services provided to the population of their territory.
*** An Act to Modify the Organization and Governance of the Health and Social Services Network, in Particular by Abolishing the Regional Agencies (CQLR, c. O-7.2).

Last updated: 2018-05-22
Authors: Catherine Labasi-Samartino, Amélie Quesnel-Vallée
Validation: Mylaine Breton

Figure 1 Organizational chart of the Quebec Ministry of Health and Social Services (as of May 2018)



4) What are the main models for delivery of front-line primary care? (e.g., autonomous private delivery, reform models by name, community health centres) What is the approximate proportion and population coverage?

A variety of primary health care organizations exist:

Local community services center (CLSCs): public ownership (under management of the CISSS/CIUSSS), public operating costs, public source of salary for MDs.

- Public clinics created in the early 1970s under the governance of the provincial government.
- Mandate of managing the health care of the population living on their territory; the development of front line social and medical programs to address the population's needs (family planning, mental health, etc.); the development of social services and a homecare program.
- Provides health and social services including preventive and curative services, and support services such as home care; routine health and social services (nursing care, blood tests, vaccinations, morning-after contraception, etc.); preventive or medical services (medical consultation with or without an appointment); rehabilitation and reintegration services; and public health activities.
- A variety of professionals work in CLSCs such as physicians, nurses, occupational therapists, physiotherapists, nutritionists, psychologists, and social workers.
- 147 CLSCs and 800 private practices make up Quebec's primary care network (Lévesque et al. 2007).
- Medical clinic; non-FMG or Network Clinic (NC, private MD ownership, private operating costs, public fee-for-service payment to MDs.

Family medicine groups (FMG):

- Attached to a CLSC: public CIUSS ownership, public operating costs, public salary to MDs.
    - FMGs sign an agreement with a CLSC, particularly for the provision of psychosocial services to the FMG's clients.
    - This group is then part of a wider network, including other FMGs, hospitals and other services.
- Attached to a medical clinic: private MDs ownership, mixed operating costs (public funds and MDs), public fee-for-service payments to MDs.
    - The MSSS developed FMGs in 2002 following the proposals included in the Clair commission (2000).
    - A FMG is a group of 6 to 12 full-time equivalent physicians working together and with other health professionals, mainly nurses, to strengthen primary care delivery

in Quebec. Their goal is to ensure the viability and accessibility of Quebec's primary health care system.

- One FMG serves around 15, 000 people and has around 10 physicians, two nurses and two administrative support staff.
- Services are provided Monday through Friday, with and without appointment. On weekends and holidays, a minimal level of walk-in services is available.
- On-call telephone response service staffed by a physician 24 hours a day, seven days a week, outside of the FMG's working hours exists for patient enrolled who meet a multitude of vulnerability criteria (e.g., elderly, chronically ill; CSBE, 2009).
- FMG services include the delivery of health services adapted to the health status of the enrolled patients, the prevention of illnesses, health promotion, health evaluation, diagnosis and treatment of acute and chronic diseases.
- Recently, the model had been extended by the MSSS by integrating social workers in FMG in 2017 (MSSS 2017).

Network clinic (CR): private MDs ownership, mixed operating costs, public fee-for-service salary to MDs.

- Implemented under the initiative of the Regional Health Agency
- Aimed to increase accessibility through walk-in visits, offer technical supports (X-rays and lab tests) and provide access to specialists.

University Family Medicine Group (GMF-U): Formerly, Family Medicine Unit (FMU). A university family medicine group GMF-U) is an FMG where family medicine residents, students and interns in various disciplines can receive training and be supervised.

- 47 GMFU across the province (Personal communication, May 22, 2018).
- The GMFU-U is distinguished from the GMF by their university affiliation and commitment to teaching. To this end, they must be recognized by the Program of family medicine by the College of Physicians of Quebec and the College of Family Physicians of Canada (MSSS 2018).
- The objectives of the GMF-U include:
    - To provide first-line health services while fulfilling the teaching responsibilities of the university.
    - Instruct practitioners in providing integrated font-line services.
    - Participate in the development and application of knowledge, notably through research and learning.

- Population coverage: As of April 2018, 79.54% of the population had a family physician (Bellerose 2018)
- In the wake of negotiations following Bill 20, an agreement was signed in April 2015 between the Department of Health and Social Services and the Quebec Federation of General Practitioners. Two targets are specified in this agreement and must be reached by December 31st, 2017 (NB: as per the bullet point above the first target has not been met as of May 2018).

- 85% of Quebec's population must be registered with a family physician.
- Physicians must attain an attendance rate of 80%.
- Although targets were not achieved by the deadline, the penalties have not been adopted.

5) What are the main reform models of primary care or primary health care (list & briefly describe)?

- **Bill 10:** Organizational reform of the system, one of the aims of which was to improve care integration (Quesnel-Vallée and Carter 2018). The RTS, CIUSSS and CISSS model is based on service hierarchy to facilitate the complementarity and continuity of services and patient transitions between primary, secondary and tertiary services.(Pineault et al. 2016). FMG is the dominant PHC model in Quebec. Currently, more than 300 FMG have been implemented across the province (Personal communication, May 22, 2018).
- **Family Medicine Groups:** This reform implemented in 2002 introduced a contractual relationship between physicians and the MSSS, represented by the regional health and social services agencies (Aubin and Quesnel-Vallée 2016). With the reform enacted by Bill 10, the FMGs are now under the mandate of the CSSS/CIUSSS.
    - The FMG model is based on voluntary participation. Physicians commit to provide a defined set of services to their enrolled patients. In exchange for their commitment, FMGs receive additional human, material and financial resources. Physicians and FMG members must sign a contract of association that sets out the orientations, the functioning and the responsibilities of each party. The physicians are responsible for defining the services they offer, such as the FMG's days and hour of operation and on-call periods, and the services provided outside the FMG. Following the approval of the FMG proposal by the MSSS, it becomes the foundation for their contract. The FMG signs an agreement with a CSSS/CIUSSS partner, which clarifies the attachment of nurses with the FMG. The nurses attached to an FMG continue to have an employment attachment with the CSSS but are under the functional authority of the FMG. The nurses' institutional link was kept to create a strong formal alliance which in turn would encourage collaboration among FMGs and between FMGs and the public institutions in the region.
    - FMG accreditation must be renewed every three years. During the renewal process, the FMG's offer of services is verified and sometimes adjusted. Medium-term objectives for the FMGs are also set by the MSSS representatives. On the other hand, FMGs expect the new renewed contracts to be accompanied with additional resources. Hence, the FMG's sustainability depends on their contract negotiated between private practice and the state that is regularly re-evaluated. This structure is implemented to ensure better accountability for primary care service organizations.
    - The FMG reform and the previously mentioned CSSS reform, were important in the way they recognized the importance of the private clinic network present in Quebec. The FMGs could be integrated in private clinics and CSSS were responsible for creating partnerships with primary health care private clinics.

    - A revised framework for the management of the FMG model was launched in 2015. The revised model included financing to support the integration of additional health and social services personnel (i.e., nurses, social workers, other health professionals, and administrative personnel; MSSS 2017).

- Most of the funding for health and social services comes from the general tax base. Thus, the risk is spread more fairly throughout society. Most of the revenues are the result of income taxes and other taxes imposed by the Quebec Government and paid into the Consolidated Revenue Fund, the Fund to Finance Health and Social Services Institutions and federal government transfers.
    - All physicians attached to the public system are paid by the RAMQ. The majority of physicians are thus self-employed workers paid through public funds.
    - For physicians operating in private practice, administrative activities and rental costs are indirectly funded through physicians' fee-for-service remuneration. These fees are upwardly adjusted to consider the practice's operating expenses.
    - In public establishments, such as CLSCs, the MSSS provides a global budget. The FMG model includes direct public funding, which is added to cover specific aspects of operating expenses such as client enrolment. These arrangements make it so private medical practices that decide to become FMGs are entitled to additional funding for operating costs, which gives them a dual profile with respect to funding. Overall, these public/private organizations have a portion of their medical practice operating costs directly funded by the MSSS and a large portion covered by the physicians (Lévesque et al. 2007). The financial subsidies and fees involved in holding the status of an FMG clinic used to be managed by the regional health and social services before the implementation of *le projet de loi 10.* The subsidies are calculated based on the number of patients enrolled and the salaries of administrative staff and part of the FMG's rental costs for additional space for staff and nurses. On average, for an FMG with around 15, 000 enrolled patients, this funding is of $270, 000 (MSSS, 2008). Although a large proportion of remuneration continued to be fee for service, amounts were added to improve working conditions in FMGs (Pomey et al., 2009). For example, doctors working in FMGs receive $10 per enrolled patient. Other services such around-the-clock phone access is paid at $58 per day and the head doctor of the FMG receives an additional $350 per week. The average cost of supplementary remuneration for each FMG is $275, 000 (Bourgueil et al., 2007).
    - FMGs have been associated with a group of contractual agreements between accredited clinics and other health institutions at the local, regional, and provincial levels. Also, regional departments of family medicine have been established in Quebec (D*épartement regional de médicine générale* – DRMG). Incorporating the changes of the latest 2015 reform, these departments are now not only composed of elected representatives from each local area's pool of general practitioners (3), but also by representatives appointed by the elected members (9). They represent one of the first attempts at integrating general practitioners into the governance of Quebec's health system. Their mandate consists of making

recommendations on the portion of the regional physician resource plan for general practitioners, define and propose the regional plan for the organization of general medical services, define and propose a network of accessibility to general care, make recommendations on the list of specific medical activities and ensure implementation, and provide its opinion on any project concerning the provision of general medical services.

References:

Aubin ÉL, Quesnel-Vallée A. 2016. Augmenter l'accessibilité et la qualité des services de santé de première ligne avec les Groupes de médecine de famille. *Health Reform Observer - Observatoire des Réformes de Santé* 4 (1): Article 5. DOI: http://dx.doi.org/10.13162/hro-ors.v4i1.2689

Bellerose, P. 2018. Accès à un médecin de famille: Barrette rate à nouveau la cible. *Le Journal de Québec.* http://www.journaldequebec.com/2018/04/26/acces-a-un-medecin-de-famille-barrette-rate-a-nouveau-la-cible

Bourgueil Y, Marek A, Mousques J. 2007. Médecine de groupe en soin primaires dans six pays européens, en Ontario et Québec: état des lieux et perspectives. *Rapport IRDES no. 1675.* Paris: Institut de recherche et documentation en économie de la santé. http://www.irdes.fr/Publications/Rapports2007/rap1675.pdf.

Breton, M., Lévesque, J. F., Pineault, R., & Hogg, W. (2011). Primary care reform: can Quebec's family medicine group model benefit from the experience of Ontario's family health teams?. *Healthcare Policy*, *7*(2), e122.

Commission d'étude sur les services de santé et les services sociaux. 2000. Les solutions emergentes – Rapport et recommandations (Rapport Clair). http://publications.msss.gouv.qc.ca/msss/document-000614/.

Commissaire à la santé et au bien-être (CSBE). 2009. Rapport d'appréciation de la performance du système de santé et de services sociaux 2009. Retrieved from: http://www.csbe.gouv.qc.ca/fileadmin/www/2009_PremiereLigne/csbe-Recommandations-t4-042009.pdf.

Lévesque JF, Roberge D, Pineault R. 2007. La Première ligne de soins : un témoin distant des réformes institutionnelles et hospitalières au Québec? In Fleury MJ, Tremblay M, Nguyen H, Bordeleau L (Eds.) *Le Système socio-sanitaire au Québec*. Montréal, QC: Gaëtan Morin

Ministère de la santé et des services sociaux (MSSS). 2008. Évaluation de l'implantation et des effets des premiers groupes de médecine de famille au Québec. http://publications.msss.gouv.qc.ca/msss/document-000879/?&date=ASC.

Ministère de la santé et des services sociaux (MSSS). 2017. Programme de financement et de soutien professionnel pour les groupes de médecine de famille. Retrieved from: http://publications.msss.gouv.qc.ca/msss/fichiers/2017/17-920-09W.pdf.

Ministère de la santé et des services sociaux (MSSS). 2018. Cadre de gestion des groupes de médecine de famille universitaires (GMF-U). Retrieved from: http://publications.msss.gouv.qc.ca/msss/fichiers/2018/18-920-22W.pdf.

Pomey M, Martin E, Forest P. 2009. Quebec's Family Medicine Groups: Innovation and Compromise in the Reform of Front-Line Care. *Canadian Political Science Review* (3) 31–46.

Quebec Medical Association. 2015. The Role of the Medical Profession in Governance of the Quebec Health Care System. Retrieved from: https://www.amq.ca/images/Prises_de_position/Rapport_gouvernance_medicale_ANG.pdf.

Quesnel-Vallée A, Carter R. 2018. Improving Accessibility to Services and Increasing Efficiency Through Merger and Centralization in Québec. Health Reform Observer - Observatoire des Réformes de Santé 6 (1): Article 2. https://doi.org/10.13162/hro-ors.v6i1.3216

Pineault R., Prud'homme A., Fiset-Laniel J., Strumpf E. 2016. Montreal's Health Care System (Quebec, Canada). Prepared for *Access to Health Services and Care Coordination in New York and Montreal*. March 2016.

Pineault R, Lévesque JF, Breton M., Hamel M., Roberge D. 2009. La Première ligne : quel rôle pour les organisations publiques, privées et mixtes? In Béland F, Contandriopoulos AP, Quesnel-Vallée A, Robert L (Eds.), *Le Privé dans la santé. Les discours et les faits*. Montréal, QC: Les Presses de l'Université de Montréal

Last-updated: 2018-05-29
Author(s): Catherine Labasi-Sammartino, Noushon Farmanara
Validation: Shelley Doucet, Noortje Kunnen (PHC Alignment Coordinator GNB)

Macro Policy Scan: New Brunswick

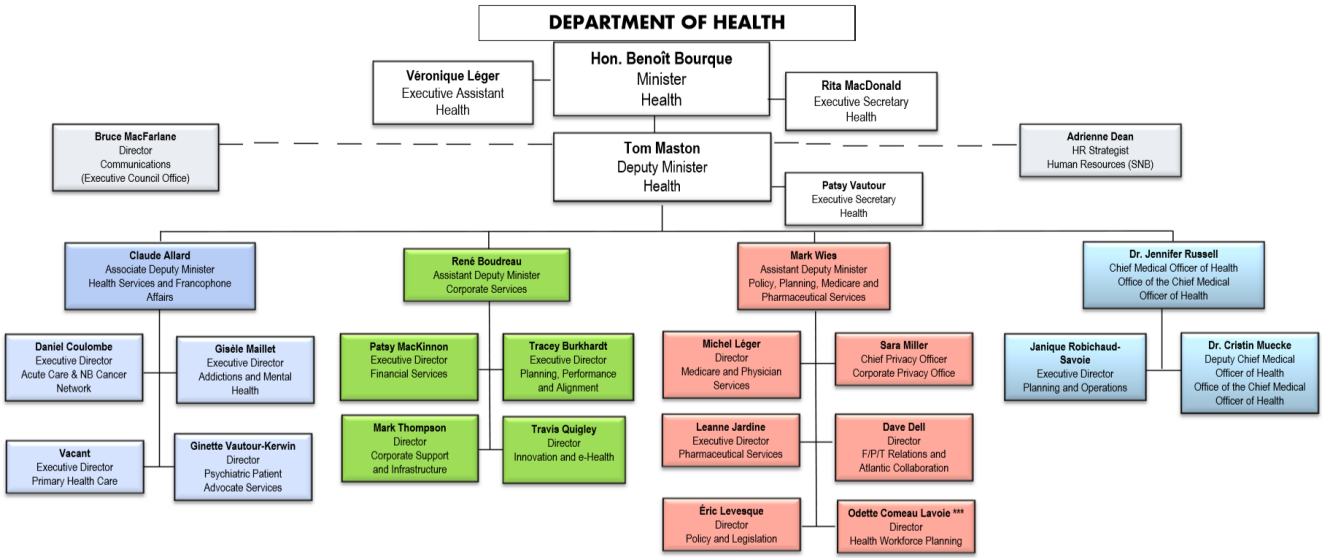
Part I: Primary Health Care Policy Structure and Scope

1) What is the formal governance structure for primary care (Ministry name, where in the structure is provincial/territorial oversight for primary care). If possible, include an organizational chart of provincial government department structure, and an organizational chart of the subsidiary branches, departments, or units of the department of health.

The Department of Health is a department within the Government of New Brunswick. The Deputy Minister and the Executive Management Committee (EMC) are the province's leaders in improving delivery of health-care services. The Deputy Minister leads the EMC team which is composed of the Associate Deputy Minister responsible for Health Services and Francophone Affairs, the Assistant Deputy Minister for Corporate Services, and the Assistant Deputy Minister for Policy, Planning, Medicare and Pharmaceutical Services (Government of New Brunswick n.d.-a). The Director of Human Resources, the Director of Communications, the Executive Director of Program Alignment and Performance, and the Chief Medial Health Officer are also members of the EMC.

The Department of Health is comprised of several divisions (see figure 1). The Health Services and Francophone Affairs division, has four branches: Addiction and Mental Health Services, Acute Care, **Primary Health Care**, and Psychiatric Patient advocate Services. The Health Services and Francophone Affairs Division has oversight over most health-care programs and services across the continuum of care within the two regional health authorities in New Brunswick (Government of New Brunswick n.d.-b).

Figure 1.2 Department of Health high-level organizational structure (as of May, 2018)



2) What specific services fall under the same governance structure as primary care? (i.e., scope – home care? Social services? End-of-life support? Any public health functions?

Primary health care in New Brunswick is defined as being first contact health care. It includes the services that individuals look for in the community and often come from family doctors, after-hours clinics, or other health professionals such as nurse practitioners, through tele-care or, pharmacists. The Primary Health Care Branch is responsible for the following units:

- Chronic Disease and Prevention Management (CDPM) and Community Health Services
  - The unit is responsible for chronic disease prevention and management programs in the province and leads New Brunswick's CDPM Strategy.
  - Provides on-going support for the provincial development and implementation of community health centres (CHCs), health service centres, and collaborative practice sites. The branch is also responsible for developing and providing training models for primary health care providers, and for developing patient engagement opportunities. In addition, it manages the provincial Tele-Care 811 Service.
  - Of note, family physicians and Family Medicine New Brunswick (discussed further in question 4) do not fall under the Family Health Care Branch, but under the Medicare and Physician Services Branch of the Policy, Planning, Medicare and Pharmaceutical Services Division (see figure 1). Among other responsibilities, the branch is in charge of physician remuneration: this includes the negotiation and interpretation of the Fee-for-Service Master Agreement and any subsidiary agreements with the New Brunswick Medical Society.
- Emergency Health Services
- The unit is responsible for oversight and provision of medical direction for ambulance services.
- Home Care (Government of New Brunswick n.d.-b).

The Health Services and Francophone Affairs Division, under which the Primary Health Care Branch falls, also has oversight over the following services: addiction and mental health; acute care (i.e., hospital services); the NB Cancer Network; and psychiatric patient advocate services.

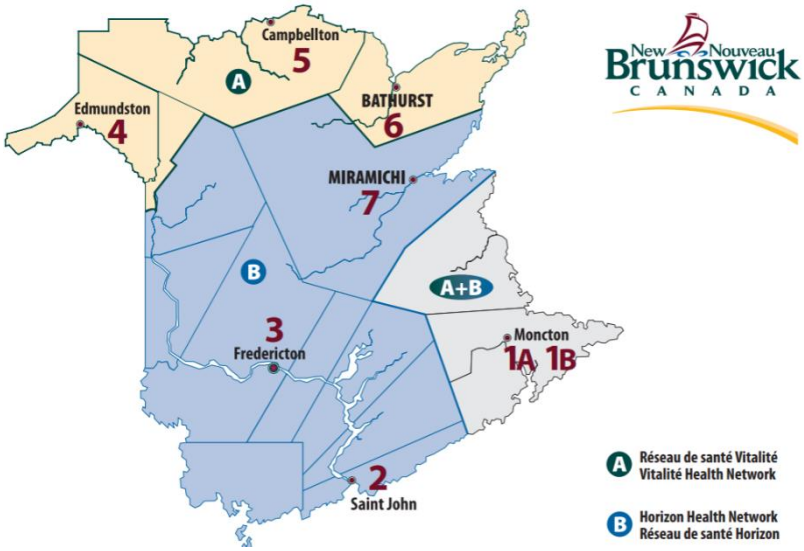
While public health services fall under the broad oversight of the Department of Health, the Office of the Chief Medical Officer of Health (Division) is responsible for the overall direction of public health programs in the province which include programs/initiatives related to health protection, healthy environments, public health practice and population health, and communicable disease control (Government of New Brunswick n.d.-b).

3) Is primary care governance and organization decentralized to the regional structures? What are the entities and scopes of responsibility?

In 2008, New Brunswick transitioned from eight Regional Health Authorities (RHAs) to two, (now):

1. Vitalité Health Network
2. Horizon Health Network

Figure 2. Map of Regional Health Authorities and Health Zones



Government of New Brunswick 2011

There are seven health zones within the province. Each RHA coordinate services within the health zones that fall within their respective health regions (see figure 2). The RHAs have a broad mandate to deliver health services within New Brunswick. Each RHA has a Board of Directors appointed by the Minister of this department. They are responsible for managing and delivering a variety of services including Hospital Services, Community Health Centre Services, Extra Mural Services, Addictions and Mental Health Services and most Public Health Services.

- As of January 1st, 2018, the delivery of services for the Extra-Mural Program was moved from the RHAs to EM/ANB, a part 3 entity, managed by Medavie Health Services New Brunswick. Ambulance New Brunswick, which used to be a separate entity, is now included under this as well. EM/ANB is accountable to the Minister of Health (Government of New Brunswick 2018).
- The Government of New Brunswick also uses the services of Service New Brunswick, a public sector company whose primary mandate is to assume responsibility for the provision of selected non-clinical services such as materials management and information systems, and human Resources.

4) What are the models for delivery of front-line primary care? (e.g., autonomous private delivery, reform models by name, community health centres?) What is the approximate proportion and population coverage?

Approximately 93.9% of the population has a regular doctor in New Brunswick compared to 85.1% in Canada (Canadian Institute for Health Information 2015).

Fee-for-service clinic/practice models: Still the primary delivery model for primary medical care in New Brunswick. Under this model, physicians are small business owners who bill Medicare for the services

provided to eligible patients, according to the billing schedule. Approximately 70% of physicians in New Brunswick practice under a fee-for-service model (New Brunswick Medical Society n.d.-a).

Community Health Centres (CHC) and Health Service Centers (HSC): Community Health Centres (CHC) provide a range of services including primary health care services, illness/injury prevention, chronic disease management, and community development services. CHCs follow a population health promotion approach to service delivery, working as an interdisciplinary team of providers (e.g., physicians, nurse practitioners, dieticians, social workers, etc.; Government of New Brunswick 2012). CHCs are governed by the Board of Directors of the RHA in which they are based. Broadly speaking, the guiding principles for CHCs in New Brunswick include:

- Providing access to culturally and linguistically appropriate primary health care services.
- Facilitating linkages with other services and sectors in the community to support positive health outcomes.
- Building on existing community infrastructure for and engaging community participation in decision-making.

The types of services offered may vary depending on the CHC and the assessment of community needs within the catchment area. Currently, there are 10 CHCs and 29 HSCs operating across New Brunswick (Canadian Association of Community Health Centres n.d.). An outline of the distribution of CHCs and HSCs by health zone is provided in the appendix. Providers under this model are primarily salaried professionals. Currently a review is underway to define Community Health Centers and their basket of services in New Brunswick (personal communication, May 29, 2018).

Family Medicine New Brunswick (FMNB): A new team-based practice initiative proposed by the New Brunswick Medical Society (NBMS) that has been initiated and will continue to be developed and implemented with the Department of Health. The program will be delivered by the NBMS through negotiated agreements with the Department of Health and is funded by the Department of Health. Two FMNB groups have been initiated since January 2018, in Oromocto and Saint John (New Brunswick Medical Society [NBMS] n.d.-b; NBMS –n.d.-c).

Walk-in/After-hours clinics: Walk-in clinics provide episode care for patients who don't have a family doctor or who are unable to obtain an appointment with their family doctor within a reasonable time frame. Walk-in clinics serve patients on a first-come, first-serve basis. After-hours clinics provide non-urgent medical care outside regular office hours and generally require patients to make appointments (NBMS n.d.-d).

Tele-care 811: A free, confidential, health advice and information line. Provides 24/7 access to bilingual registered nurses. Nurses will assess the situation and provide information and advice on next steps. Individuals without a primary health-care provider can also use the service to register with Patient Connect NB, the provincial patient registry for unattached New Brunswickers (Government of New Brunswick n.d.-d).

Patient Connect NB: The New Brunswick Health Department launched Patient Connect NB in May of 2013, a province-wide bilingual patient registry for New Brunswickers without access to a primary health care provider (i.e., family physician or nurse practitioner). Patients can register to the system and are assigned to a provider on a first-come, first-serve basis.

Community Mental Health Centres (CMHC): Although not seen as a primary health care initiative from the Department of Health perspective (these centres would fall under Addictions and Mental Health), CMHCs provide a variety of prevention, intervention, and post-intervention services in New Brunswick. At the RHA-level, these would fall under Community Services. The services provided by CMHCs are encompassed within three core programs targeting three specific populations: (1) Children and adolescents, (2) adults with short-term needs, and (3) adults with long-term needs. After an initial assessment of needs, patients may have access to various programs at the primary, secondary, or tertiary intervention level. Each CMHC is responsible for managing the core programs in its catchment area. CMHCs also aim to ensure effective coordination of services with psychiatric units and other relevant agencies in the region. There are 14 CMHCs currently available across the province (Government of New Brunswick n.d.-c; GNB 2012).

5) What are the main reform models of primary care/primary health care (list & briefly describe)?

RECENT KEY INITIATIVES:

Family Medicine New Brunswick: team-based practice initiative proposed by the New Brunswick Medical Society (NBMS) that has been initiated and will continue to be developed and implemented with the Department of Health. The program will be delivered by the NBMS through negotiated agreements with the Department of Health and is funded by the Department of Health (New Brunswick Medical Society [NBMS] n.d.-b; NBMS –n.d.-c). Key characteristics of this model include:

- Family doctors may voluntarily participate to work as part of a team of physicians to form a FMNB Group. Physicians need not be co-located. Physicians who participate in a FMNB group are not permitted to work in walk-in or after-hours clinics.
- Patients with participating physicians are asked to formally enroll with the physician for medical care and become a 'rostered' patient. Once patients are enrolled, they are assigned to the physician's group and are expected to visit their family doctor for routine care. Patients are encouraged to seek care within their family doctor's group before seeking care from another family physician.
    - If an enrolled patient receives services from a walk-in/after-hours clinic or another family physician, a deduction is made from the assigned family physician's capitation payments (to the value of the service).
- If a patient's family physician is not available, patients will be able to access another physician participating in the group. To facilitate this, FMNB groups must use the provincial electronic medical record (EMR) to keep track of patient information that can then be shared with any family doctor in the group.

- Although exact requirements are pending, FMNB Groups must also offer some degree of access to a family physician during extended weekday hours and over the weekend. Some access to care with a patient's family physician may also be allowed over the phone or by email.
- Other health professionals may also be involved in FMNB Groups – primarily, nursing professionals. No formal requirements for inter-professional collaboration have been established.
- The FMNB Group model also includes a mixed compensation method. Reimbursement will be delivered through a combination of capitation (~60%) and fee-for-service (~40%).
    - Fee-for-services billing rules will be modified to accommodate nursing care provided by the Group, as well as telephone and email advice codes.
    - Financial support will also be provided to groups (through the Department of Health and the medical society) for administrative and overhead costs.

Midwifery Demonstration Pilot: As part of the integrated care framework detailed in the *New Brunswick Family Plan: Improving Access to Primary Care* report (Province of New Brunswick 2017), the government of New Brunswick proposed the goal of maximizing the use of primary health care professionals, such as midwives, to better manage health conditions within the community and to reduce pressure on resource-intensive acute care services. In 2016, the provincial government announced that Fredericton would be the demonstration site for formally introducing midwives into the health-care system. Within the demonstration site, a lead midwife would assist in the development of policies and procedures to effectively integrate midwifery practice into existing systems. Three additional midwives would then be recruited to the site (Government of New Brunswick 2016). The official opening of the midwifery clinic took place in October of 2018, and the site is managed by the Horizon Health Network.

Home First: Launched in 2014, *Home First* is a three-year strategy developed through a partnership between the departments of Health, Social Development, and Healthy & Inclusive Communities, and the RHAs to help seniors maintain their independence and remain in their homes and communities for as long as possible (Province of New Brunswick 2013). The strategy includes targeted funding towards initiatives such as home safety assessments/consultations, growth of the home support sector, and identifying alternative models of community-based care for seniors (Government of New Brunswick 2014).

PROVINCIAL STRATEGIES AND FRAMEWORKS:

Primary Health Care Framework (2012): The Government of New Brunswick released its Primary Health Care Framework in 2012, which reflected the government's strategic plan for primary health care renewal in the province. Five categories of recommendations were proposed through the framework:

1. Integration of primary health care services
    - Stemming from weak linkages between primary health care providers and RHA resources (e.g., nurses, allied health providers, etc.)

- Encourage community health needs assessments to identify assets, strengths, and gaps in the health system. This would serve as input for assembling Collaborative Services Committees (CSC). These CSCs would serve as an organizational body at the community level to facilitate linkages between the government and providers.

2. Community-specific team-based care
   - Three primary elements:
     - Establishing team-based models of care and moving away from solo-provider care models.
     - Establishing EMR systems within team-based settings.
     - Creating a provincial patient attachment registry ("Connect-NB")
3. Accountability
   - Implementation of an accountability framework that outlines performance indicators for measurement and monitoring of the health system. Indicators should focus on the process of care, outcomes of care, and patient/caregiver satisfaction.
4. Stakeholder and patient engagement
   - Ensuring that stakeholders are kept aware of primary health care initiatives and are consulted throughout the process. The development of patient networks to engage patients at a systems-level in planning and designing health-care services.
5. Leadership for system transformation.

Rebuilding Health Care Together: The Provincial Health Plan 2013-18:
The Government of New Brunswick released its most recent five-year provincial plan that provides a 'blueprint' for the delivery of health services in the province (Province of New Brunswick 2013). Stakeholder and public input contributed to the development of the plan through a series of consultations led by the Minister of Health and the NBHC. The provincial plan builds on the 2008 plan and the 2012 Primary Health Care Framework. Along with presenting the overall strategy it outlines additional in-progress or future targeted initiatives. Again, promoting better access to patient-focused, interprofessional care is at the core of the strategy.

New Brunswick Family Plan: Improving Access to Primary and Acute Care (2017)
Released in April 2017, the New Brunswick Family Plan hinges on the understanding that "an integrated system of health and social care will help vulnerable populations lead independent, healthy, and productive lives." (Province of New Brunswick 2017) Thus, the Family Plan builds on previous goals and achievements from the province's economic growth and education plans. The foundation of the Family Plan is broadly represented through seven pillars:

- Improving Access to primary and acute care
- Promoting wellness
- Supporting those with addictions and mental health challenges
- Fostering health aging and support for seniors
- Advancing women's equality
- Reducing poverty; and
- Providing support for persons living with a disability.

Under these seven pillars, the province has put forward a series of goals and actions within four areas of focus:

- Shifting focus away from hospital-based care to preventative interventions, primary health care, and access to care in the community.
- Better access to patient-focused care through interdisciplinary teams as part of an integrated treatment framework.
- Prevention and management of chronic diseases and providing better access to prescription drugs.
- Leveraging expertise and resources to increase capacity in the health care system; and,
- Facilitating access to programs and services in the health care system.

Previously, the province had also put forward a more focused framework for addressing chronic disease prevention and management, in addition to a provincial strategy for diabetes (New Brunswick Department of Health 2010, 2011).

Of note, in the wake of the federal government's Primary Health Care Transition Fund, New Brunswick received $15 million in funding that was directed towards six main initiatives (Government of New Brunswick 2012):

1. Establish 7 community health centres. In these centres, a range of allied health professionals would support physician care.
2. Delivering interdisciplinary provider education, envisioned through the *Building a Better Tomorrow* program.
3. Implementing collaborative practice models for primary (medical) care delivery (i.e., physicians working with nurse practitioners).
4. Enhancing Tele-Care services.
5. Exploring use of advanced care paramedics and introducing primary care paramedics.
6. Integrating Ambulance services under a single provider.

References:

Canadian Association of Community Health Centres. n.d. Members: Canada's CHC Leaders. Retrieved from: https://www.cachc.ca/ourmembers/?sort=3&dir=asc.

Canadian Institute for Health Information. (2015). Your Health System: Have a Regular Doctor. Retrieved from: https://yourhealthsystem.cihi.ca/hsp/inbrief?lang=en#!/indicators/001/have-a-regular-doctor.

Department of Health and Wellness. (2003). The New Brunswick Community Health Centres Framework. New Brunswick: Government of New Brunswick. Retrieved from: https://www.slideshare.net/primary/the-nb-community-health-centers-framework

Government of New Brunswick. (n.d.-a). Department of Health: Structure. Retrieved from: http://www2.gnb.ca/content/gnb/en/departments/health/contacts/dept_renderer.141.html#structure.

Government of New Brunswick. (n.d.-b). Department of Health: Mandates. Retrieved from: http://www2.gnb.ca/content/gnb/en/departments/health/contacts/dept_renderer.141.html#mandates

Government of New Brunswick. (n.d.-c). Community Mental Health Centres – Core Programs. Retrieved from: https://www.gnb.ca/0055/cmhcs-e.asp.

Government of New Brunswick. (n.d.-d). Health Care System. Retrieved from: http://welcomenb.ca/content/wel-bien/en/LivingSettling/content/Healthcare.html.

Government of New Brunswick. (2011). Regional Health Authorities Map. Retrieved from: https://www.gnb.ca/0051/pdf/2011/HealthZones_map.pdf.

Government of New Brunswick. (2012). A Primary Health Care Framework for New Brunswick. Retrieved from: https://www.gnb.ca/0053/phc/pdf/2012/8752_EN%20Web.pdf.

Government of New Brunswick. (2014). Details of first-year investments in the Home First Strategy unveiled. News release. Retrieved from: http://www2.gnb.ca/content/gnb/en/news/news_release.2014.05.0550.html.

Government of New Brunswick. (2014). Operational Guide for Family Health Teams. Retrieved from: http://leg-horizon.gnb.ca/e-repository/monographs/31000000048289/31000000048289.pdf.

Government of New Brunswick. (2016). Fredericton chosen as demonstration site for midwives. News Release (December 5, 2016). Retrieved from: https://www2.gnb.ca/content/gnb/en/departments/health/news/news_release.2016.12.1172.html.

Government of New Brunswick. (2018). New Brunswick Provincial Extra-Mural Program Services Agreement. Retrieved from: https://www2.gnb.ca/content/dam/gnb/Departments/h-s/pdf/en/extramural/AgreementAndSchedules.pdf.

Department of Health. (2010). A Chronic Disease Prevention and Management Framework for New Brunswick. Retrieved from: https://www.gnb.ca/0051/pub/pdf/2010/6960e-final.pdf.

Department of Health. (2011). A Comprehensive Diabetes Strategy for New Brunswickers: 2011-2015. Retrieved from: https://www.gnb.ca/0053/phc/pdf/2011/8023-e.pdf.

Health Canada. (2006). Building a Better Tomorrow – Engaging Current Providers in a Renewed Primary

Health Care System for Atlantic Canada. Retrieved from: http://www.apps.hc-sc.gc.ca/hcs-sss/phctf-fassp.nsf/lkAttachments/5D73B57C311ACEBB8525728F0064C272/$File/32E_SUM_BBT.pdf.

Mable, A.L., & Marriott, J. (2012). Canadian Primary Healthcare Policy: The Evolving Status of Reform. Canadian Health Services Research Foundation. Retrieved from: https://www.cfhi-fcass.ca/Libraries/Commissioned_Research_Reports/MariottMable-Jan2012-E.sflb.ashx.

New Brunswick Health Council. (2016). Mandate. Retrieved from: https://www.nbhc.ca/about-nbhc/mandate#.WvmNn9OUuqA.

New Brunswick Medical Society (n.d.-a). How are doctors paid? Retrieved from: https://www.nbms.nb.ca/patient-information/how-are-doctors-paid/

New Brunswick Medical Society. (n.d.-b). Family Medicine New Brunswick. Retrieved from: https://www.nbms.nb.ca/leadership-and-advocacy/improving-the-health-system/a-new-model-for-family-medicine-in-new-brunswick/

New Brunswick Medical Society. (n.d.-c). A Guide to Family Medicine New Brunswick. Retrieved from: https://www.nbms.nb.ca/assets/Members-Only/FMNB/P04-17174-Guide-to-FMNB-Eng.pdf.

New Brunswick Medical Society. (n.d.-d). After-hours Clinics or Walk-in Clinics. Retrieved from: https://www.nbms.nb.ca/patient-information/after-hours-clinics-or-walk-in-clinics/

Patient Medical Home. (n.d.). Primary Medical Home in New Brunswick. Retrieve from: http://patientsmedicalhome.ca/pmh-in-canada/pmh-new-brunswick/.

Province of New Brunswick. (2008). Transforming New Brunswick's Health-care System: The Provincial Health Plan 2008-2012.

Province of New Brunswick. (2013). The Provincial Health Plan: 2013-2018. Retrieved from: https://www.gnb.ca/0212/values/pdf/9129%20english.pdf.

Province of New Brunswick. (2017). New Brunswick Family Plan: Improving Access to Primary and Acute Care. Retrieved from: https://www2.gnb.ca/content/dam/gnb/Departments/eco-bce/Promo/family_plan/acute_care.pdf.

Last-updated: 2018-05-29
Author(s): Catherine Labasi-Sammartino, Noushon Farmanara
Validation: Shelley Doucet, Noortje Kunnen (PHC Alignment Coordinator GNB)

Table 1: Number of Community Health Centers (CHCs) and Health Services Centers (HSCs) by health zone

Zone	No. of Community Health Centres	No. of Health Services Centres
1	1	4
2	1 (+3 satellite sites)	6
3	5 (+1 satellite)	9
4	0	2
5	1	1
6	2 (+1 satellite)	3
7	0	4
Total	10	29

Table 2: Name of CHCs and HSCs by health zone

Zone	CHC	HSC
Zone 1: Moncton Beauséjour	Albert County Health and Wellness centre	- Centre medical regional de Shediac (Vitalité) - Rexton HSC (Horizon) - Port Elgin and region HSC (Horizon) - Peticodiac HSC (Horizon)
Zone 2: Saint John	St Joseph CHC (+3 satellite sites) - Medisanté Saint Jean - Marketplace Wellness - Hope Wellness Center	- Fundy HSC - Deer Island HSC - Campobello HSC
Zone 3: Fredericton	Oromocto (+1 satellite site) Fredericton Downtown CHC - Noreen Richard Center Queen's North CHC Central Miramichi CHC Tobique Valley CHC	- Boiestown HSC - Chipman HSC - Fredericton Junction HSC - Harvey HSC - McAdam HSC - Nackawic HSC - Stanley HSC
Zone 4: Edmundston	n/a	- Sainte Anne de Madawaska HSC - Clinique de santé Clair (Haut Madawaska)
Zone 5: Restigouche	St Joseph's Dalhousie CHC	- Jacket River HSC
Zone 6: Acadian Peninsula	Lamèque CHC (+2 satellite sites) - Miscou - Paquetville St Isidore CHC	- Centre de santé Chaleur HSC
Zone 7: Miramichi	n/a	- Neguac HSC - Rogersville HSC - Baie Ste Anne HSC - Blackville HSC

Last-updated: 2018-04-16
Author(s): Laura Lee Madden
Validation: Erin Christian, Tara Sampalli

Macro Policy Scan: NOVA SCOTIA

Part I: Primary Health Care Policy Structure and Scope

1) What is the formal governance structure for primary care (Ministry name, where in the structure is provincial/territorial oversight for primary care)? If possible, include an organizational chart of provincial government department structure, and an organizational chart of the subsidiary branches, departments, or units of the department of health.

The Nova Scotia government has 19 departments, one of which is the Department of Health and Wellness (DHW; beta.novascotia.ca, n.d.):

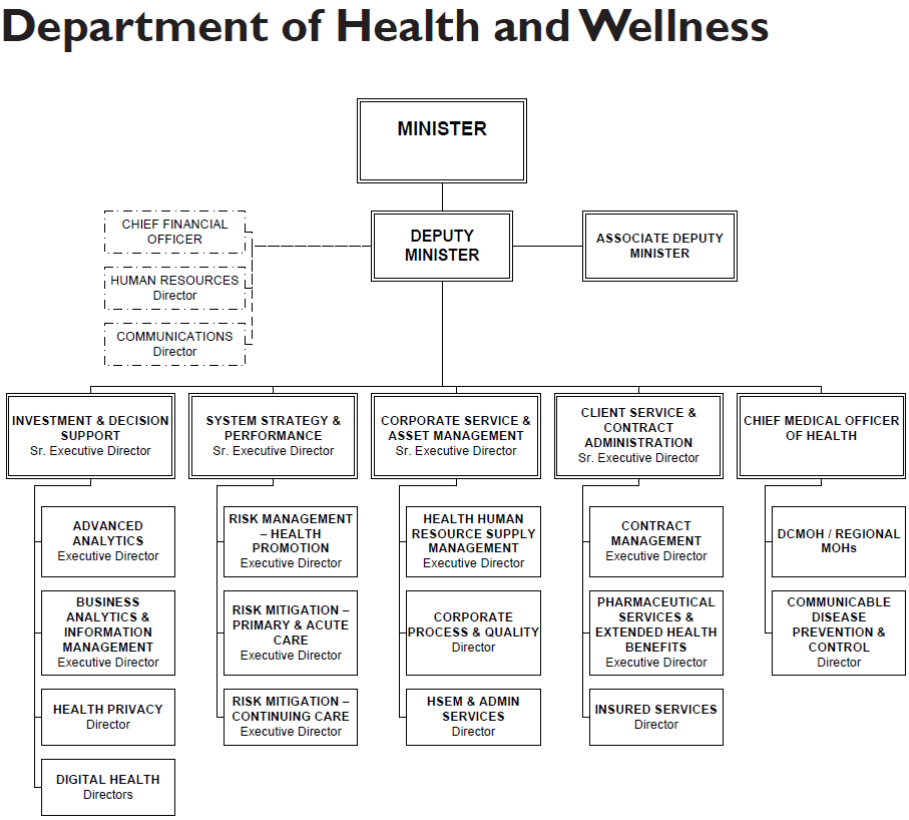
1. Agriculture
2. Business
3. Communities, culture and heritage
4. Community Services
5. Education and early childhood
6. Energy
7. Environment
8. Finance and treasury board
9. Fisheries and Aquaculture
10. Health and Wellness
11. Intergovernmental affairs
12. Internal services
13. Justice
14. Labour and advanced education
15. Municipal affairs
16. Natural resources
17. Public service commission
18. Seniors
19. Transportation and infrastructure renewal

The DHW is organized into five divisions (Government of Nova Scotia, 2017):

1. Investment and Decision Support
2. System Strategy and Performance
3. Corporate Services and Asset Management
4. Client Service and Contract Administration
5. Office of the Chief Medical Officer of Health

Last-updated: 2018-04-16
Author(s): Laura Lee Madden
Validation: Erin Christian, Tara Sampalli

Primary health care falls within the scope of Risk Mitigation – Primary and Acute Care under the System Strategy and Performance division, within the Department of Health and Wellness (Government of Nova Scotia, 2017).



(Government of Nova Scotia, 2017)

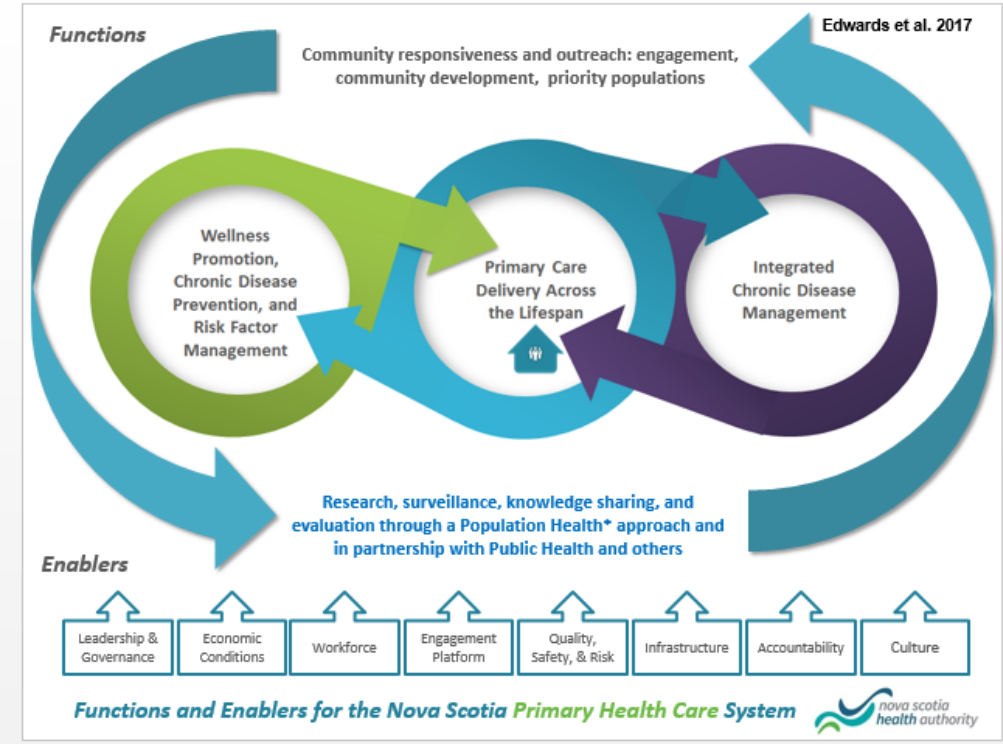
2) What specific services fall under the same governance structure as primary care? (i.e., scope – home care? Social services? End-of-life support? Any public health functions?)

Primary care falls under the System Strategy and Performance division within the DHW (Government of Nova Scotia, 2017). This division is responsible for the development and monitoring of health system risk mitigation and management strategies for primary health care, acute care, health promotion/prevention, continuing care, and mental health and addictions (Government of Nova Scotia, 2017). This division provides governance to ensure that all initiatives are performance-based, evidence-informed, and attached to frameworks of accountability that lead to the improvement of the system and associated population health outcomes (Government of Nova Scotia, 2017). It also regularly evaluates, audits, and reports on system performance (Government of Nova Scotia, 2017). In addition, this division oversees the mitigation and management of risks related to the sustainability and affordability of the public health insurance structure and the health and wellness of Nova Scotia residents (Government of Nova Scotia, 2017).

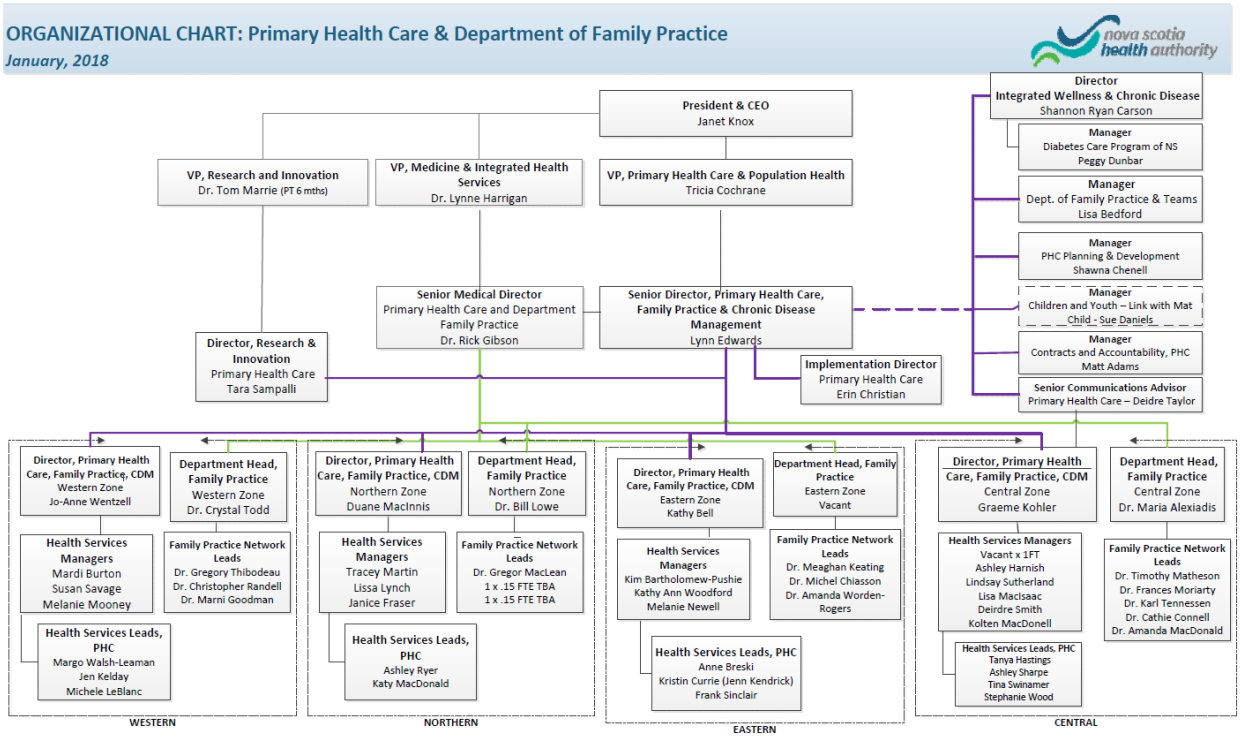
Last-updated: 2018-04-16
Author(s): Laura Lee Madden
Validation: Erin Christian, Tara Sampalli

3) Is primary care governance and organization decentralized to the regional structures? What are the entities and scopes of responsibility?

Nova Scotia Health Authority's (NSHA) was formed in 2015 as a merger of the pre-existing nine district health authorities. Its mission is "to achieve excellence in health, healing and learning through working together" (nshealth.ca, 2017). Its purpose is to plan and deliver primary care, community health, and acute care to Nova Scotians through hospitals, health centres, clinics, schools, and community settings.



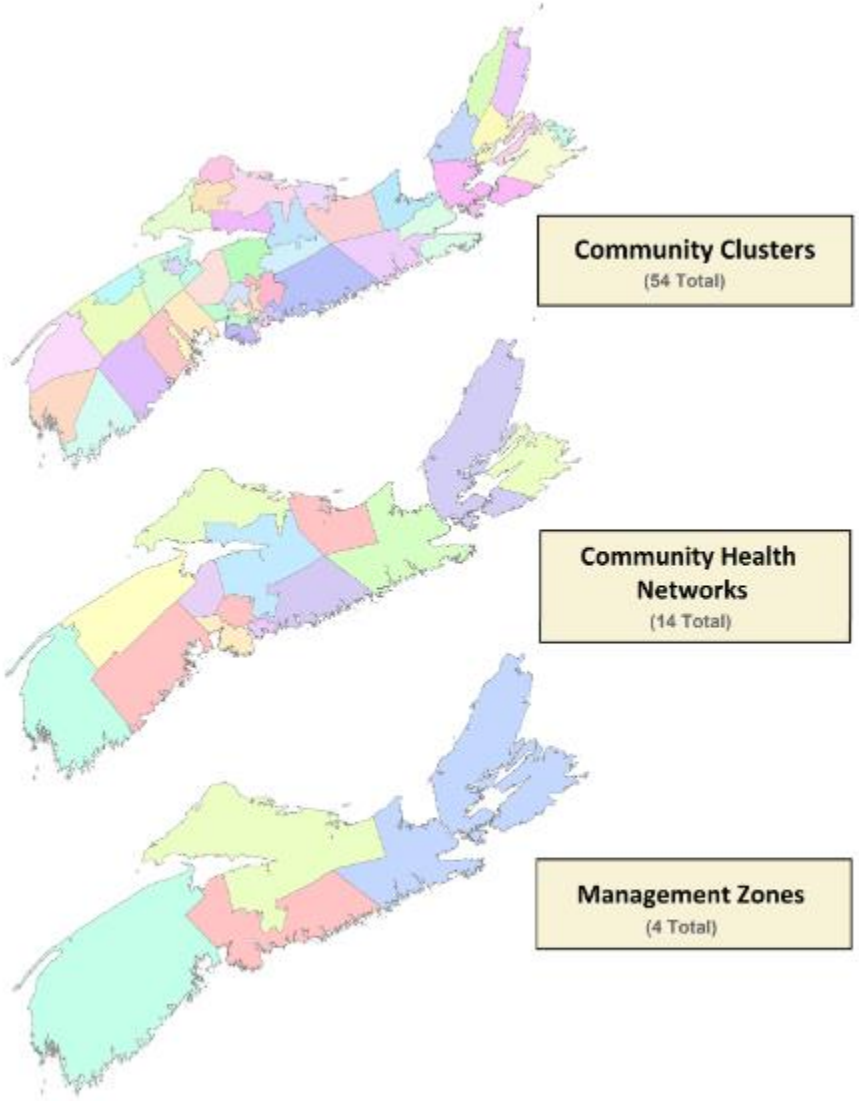
When consolidating the health care structure into the centralized NSHA, the government believed that local leadership plays an important and relevant role (novascotia.ca, 2015). Therefore, the government chose to maintain local operational and clinical leadership by creating four health authority zones (novascotia.ca, 2015).



The NSHA is made up of four zones: western, eastern, northern, and central (novascotia.ca, 2015). Zone boundaries were determined based on several considerations including: medical staff relationships, traditional community affiliations, where residents typically access health services, planning processes that addressed boundary issues, the geographic boundaries utilized by Community Services and other connected services, and the enabling and limiting impact of geographic boundaries to future clinical services planning (novascotia.ca, 2015).

(novascotia.ca, 2015)

In addition, a team of researchers and officials from the DHW, NSHA, and the Maritime SPOR SUPPORT Unit (MSSU), worked to develop a set of geographic area units to set boundaries that appropriately align with services and the communities they serve, thereby aiding in planning for primary healthcare (Terashima, et al., 2016). The result of this work was 54 community clusters within 14 community health networks under the four health authority management zones (Terashima, et al., 2016).



(Terashima, et al., 2016, p. 9)

4) What are the models for delivery of front-line primary care? (e.g., autonomous private delivery, reform models by name, community health centres) What is the approximate proportion and population coverage?

Last-updated: 2018-04-16
Author(s): Laura Lee Madden
Validation: Erin Christian, Tara Sampalli

Most physicians in Nova Scotia are self-employed in private practices (careers.novascotia.ca, 2018). Most physicians are compensated through fee-for-service, whereby fees are paid by the government for specific services and based on the number of patients served (careers.novascotia.ca, 2018). However, some physicians are compensated through alternative funding plans (careers.novascotia.ca, 2018).

There are currently four primary care practice models (Christian, 2018):

Solo practice: Solo practice involves a single physician, aided by a small staff. The small size allows the single physician autonomy to grow and design their own practice but limits the number of patients seen at the practice (Masters, 2017).

Group practice: A group practice is a medical practice whereby two or more physicians offer care to patients in the same setting (Masters, 2017).

Co-located: Co-located practices have multiple services available in the same physical space (Ginsburg, 2008). Physical proximity of services can assist with the coordination of services to address the multiple needs of a patient, thereby enhancing the outcomes of services (Ginsburg, 2008).

Collaborative family practice team: A collaborative family practice team allows health professionals such as family doctors, family practice nurses, and nurse practitioners to work together to provide care that is comprehensive, accessible, coordinated, continuous, and community-oriented (nshealth.ca, 2017). Teams can also include social workers, occupational therapists, physiotherapists, dieticians, and other health professionals (Nova Scotia Health Authority). A collaborative family practice team must have at least three primary health care providers, coming from two or more professional disciplines (nshealth.ca, 2017). There are currently about 50 collaborative family practice team locations in Nova Scotia (nshealth.ca, 2017).

Going forward, the NSHA recommends three models for the management of team-based care (Christian, 2018). The type of model will help to determine the logistics of running a team-based practice, including responsibility for hiring and clinic space, funding for staffing and operating costs, and the running of day-to-day operations (Nova Scotia Health Authority). The three recommended models are:

- Contracted services: In the contracted services model, the responsibility for the administration and operation of the team rests with the team of health professionals (Nova Scotia Health Authority).
- Co-leadership: In the co-leadership model, the responsibility for operations and administration is shared between the team and the NSHA (Nova Scotia Health Authority).
- Turn-key: There are also various turn-key methods, whereby the NSHA has greater responsibility in the administration and operation of the practice (Nova Scotia Health Authority).

Community Health Centres: Community Health Centres are a subtype of the collaborative team model but with a different governance structure (Christian, 2018). They are supported by the Nova Scotia Association of Community Health Centres with the aim of improving Nova Scotians' health and

wellbeing (nsachc.org, n.d.). They provide accessible, timely, and people-centred primary care, social services, and health promotion services (nsachc.org, n.d.). Community health centres are effective at meeting the specific and complex needs of communities, individuals and families that deal with barriers to health such as geographic isolation and socio-economic factors (nsachc.org, n.d.).

5) What are the main reform models of primary care/primary health care (list & briefly describe)?

Person-Centred Health Home Model: Proposed in 2017 by the NSHA, the person-centred health home model seeks to promote access to coordinated, continuous, comprehensive, and timely primary health care through collaborative family practice teams (Primary Health Care, NSHA, 2017). The model focuses on accountability, safety, quality, and the needs of the population with the intent to improve health outcomes for individuals and families (Primary Health Care, NSHA, 2017). The idea is that a patient's health home would include a main primary care provider along with an interprofessional team of providers that acts as a hub for the coordination of comprehensive medical care services (Primary Health Care, NSHA, 2017). The use of a comprehensive electronic medical record (EMR) is also noted as an important feature of this model (Primary Health Care, NSHA, 2017). The NSHA envisions that through this model, Nova Scotians will receive and have access to comprehensive services from a collaborative interprofessional family practice team in their Health Home, thereby allowing Nova Scotians to work in partnership with their Health Home team and participate in their own coordinated and continuous care throughout their lives (Primary Health Care, NSHA, 2017).

Collaborative Family Practice Teams: The DHW and NSHA are supporting Primary Health Care's development of collaborative family practice teams across Nova Scotia. Currently, there are approximately 50 in various stages of development. A collaborative family practice team must consist of at least the primary health care providers with two or more professional disciplines (nshealth.ca, 2017).

Registered Nurse Act: The Registered Nurse Act was introduced in 2001 and provided the legal framework necessary for the inclusion of nurse practitioners into regular collaborative family practice (Levesque, et al., 2012).

Building a Better Tomorrow Together (BBTT): BBTT is a provincial initiative involving a series of continuing education modules that encourage health care providers to develop, support, and integrate collaborative interdisciplinary teams into their practices (nshealth.ca, n.d.).

Strengthening Primary Healthcare Initiative (SPCI): SPCI was launched in 1998 by the Government of Nova Scotia to evaluate patient-centred primary health care, illness prevention and health promotion in clinical practice, team collaboration and accountability, responsiveness to community needs, and improved access (Levesque, et al., 2012). This initiative was funded by the Health Transition Fund and the Primary Health Care Transition Fund and was introduced at four sites for a three-year time period (Levesque, et al., 2012). The main components of the initiative were to experiment with new payment mechanisms, implement EMRs, introduce nurse practitioners into collaborative practices, build

relationships with community organizations, and involve individuals from the community in governance (Levesque, et al., 2012).

Family Practice Nurse (FPN) Initiative: The FPN initiative is an educational support program which encourages the expansion of interdisciplinary teams by supporting the addition of family practice nurses to primary care clinics (Levesque, et al., 2012). This initiative includes resource kits and education for registered nurses as well as information for physicians (Levesque, et al., 2012). Currently, there are more than 35 FPNs working in primary care within the NSHA (nshealth.ca, n.d.).

Community Health Teams (CHTs): Capital District Health Authority implemented CHTs using community-engagement strategies and population-based planning with the intention of regrouping and creating resources for zones and geographic entities (Levesque, et al., 2012). The initiative included two main components: Wellness Programming and Wellness Navigation (Levesque, et al., 2012). Within Wellness Programming, the CHT supports and provides access to wellness programs that complement those programs already present in the community (Levesque, et al., 2012). Within Wellness Navigation, the CHT works collaboratively with community groups, specialty programs, family physicians, and other providers and groups to support and link individuals and families with appropriate programs, supports, and services (Levesque, et al., 2012).

Social Inclusion and Cultural Competence Program: This program provides guidelines and continuing education to providers to increase their awareness of social diversity and multiculturalism needs (Levesque, et al., 2012). Cultural competency and social inclusion help to reduce the impacts of social determinants of health and health inequities for marginalized people as well as support the management and prevention of chronic diseases and enhance culturally effective access to programs and services (novascotia.ca, 2017).

HealthLink 811: Health Link was implemented in Nova Scotia for 24/7 telephone assistance (Levesque, et al., 2012). By dialing 811, Nova Scotians are connected with an experienced registered nurse who can assist them with their health concerns and questions (novascotia.ca, 2017).

Primary Health Care Information Management and Electronic Medical Records (PHIM): PHIM was implemented to support providers in the implementation of EMR systems (Levesque, et al., 2012). The use of EMRs allows primary health care teams and hospital health professionals to have reliable, accurate, and up-to-date information about their patients' health (novascotia.ca, 2017). This improves continuity and quality of care (novascotia.ca, 2017).

A Novel Approach to Cardiovascular Health by Optimizing Risk (ANCHOR): The ANCHOR project aims to use multidisciplinary teams to improve prevention of cardiovascular disease (Levesque, et al., 2012).

Chronic Disease Prevention and Management: Nova Scotia is working towards a more proactive, patient-driven approach to the management of chronic disease (novascotia.ca, 2013). This is being done through the uptake of collaborative primary health care teams, investments in chronic disease self-management support, initiatives, and programs, and support for the implementation of EMRs and the

use of care guidelines (novascotia.ca, 2013). Primary health care works collaboratively with partners to support patients' adoption of health behaviours, including being physically active, avoiding tobacco use, and eating nutritious foods (novascotia.ca, 2013).

References:

beta.novascotia.ca. (n.d.). Government Departments. Retrieved February 13, 2018, from Nova Scotia: https://beta.novascotia.ca/government/

careers.novascotia.ca. (2018, February 13). Family Physicians and General Practitioners. Retrieved February 13, 2018, from Nova Scotia: https://careers.novascotia.ca/occupation/143

Christian, E. (2018, January 21). (Personal communication). Halifax, Nova Scotia.

Ginsburg, S. (2008, July). Colocating Health Services: A Way to Improve Coordination of Children's Health Care. The Commonwealth Fund, 41. Retrieved February 13, 2018, from http://www.commonwealthfund.org/usr_doc/Ginsburg_Colocation_Issue_Brief.pdf

Government of Nova Scotia. (2017). Department of Health and Wellness. Department of Health and Wellness. Government of Nova Scotia.

Levesque, J.-F., Pineault, R., Grimard, D., Burge, F., Haggerty, J., Hogg, W., & Wong, S. (2012). Looking Backward to Move Forward: A Synthesis of Primary Health Care Reform Evaluation in Canadian Provinces. Agence de la sante et des services sociaux de Montreal/Direction de sante publique, Institut natoinal de sante publique du Quebec. Retrieved February 13, 2018, from https://www.inspq.qc.ca/pdf/publications/1439_RegarderArriereMieuxAvancer_SynthEvalReforSoins1Ligne_VA.pdf

Masters, P. (2017). Types of Medical Practices. Retrieved February 13, 2018, from American College of Physicians: https://www.acponline.org/about-acp/about-internal-medicine/career-paths/residency-career-counseling/guidance/types-of-medical-practices

Nova Scotia Health Authority. (n.d.). Frequently Asked Questions - Expression of Interest for Collaborative Family Practice Teams. Nova Scotia Health Authority. Retrieved February 13, 2018, from https://www.google.ca/url?sa=t&rct=j&q=&esrc=s&source=web&cd=2&cad=rja&uact=8&ved=0ahUKEwj439-20vPYAhXNzqQKHUb8Dh4QFggwMAE&url=https%3A%2F%2Fwww.cdha.nshealth.ca%2Fsystem%2Ffiles%2Fsites%2Fdocuments%2Fcfp-eoi-faq.pdf&usg=AOvVaw0YyblWMfMzfmrFALfxd5ju

novascotia.ca. (2013, September 26). Primary Health Care - Chronic Disease Prevention and Management. Retrieved February 13, 2018, from Nova Scotia: https://novascotia.ca/dhw/primaryhealthcare/chronic-disease-management.asp

novascotia.ca. (2015, February 12). District Health Authority Consolidation People Centred Health Care Info - Nova Scotia Health Authority Zones. District Health Authority Consolidation Transition & Design Team. Nova Scotia. Retrieved February 13, 2018, from http://transformphc.sites.olt.ubc.ca/files/2014/04/NS-Management-Zones.pdf

novascotia.ca. (2017, December 10). HealthLink 811 Line Launched. Retrieved February 13, 2018, from Nova Scotia: https://novascotia.ca/news/smr/2009-07-29-healthlink.asp

novascotia.ca. (2017, December 10). Primary Health Care - Primary Health Information Management. Retrieved February 13, 2018, from Nova Scotia: https://novascotia.ca/dhw/primaryhealthcare/PHIM-EMR.asp

novascotia.ca. (2017, December 10). Primary Health Care - Resources for Healthcare Providers. Retrieved February 13, 2018, from Nova Scotia: https://novascotia.ca/dhw/primaryhealthcare/resources.asp

nsachc.org. (n.d.). About NSACHC. Retrieved February 13, 2018, from Nova Scotia Association of Community Health Centres: http://www.nsachc.org/about/

nshealth.ca. (2017). About Us. Retrieved February 13, 2018, from Nova Scotia Health Authority: http://www.nshealth.ca/about-us

nshealth.ca. (2017). Collaborative Family Practice Teams. Retrieved February 13, 2018, from Nova Scotia Health Authority: http://www.nshealth.ca/collaborative-family-practice-teams

nshealth.ca. (n.d.). Department of Family Practice - Building a Better Tomorrow Together (BBTT) - DFP. Retrieved February 13, 2018, from Nova Scotia Health Authority: https://www.cdha.nshealth.ca/district-department-family-practice/practice-support/building-better-tomorrow-together

nshealth.ca. (n.d.). Department of Family Practice - Family Practice Nurse Program - DFP. Retrieved February 13, 2018, from Nova Scotia Health Authority: https://www.cdha.nshealth.ca/district-department-family-practice/practice-support/family-practice-nurse-program

Primary Health Care, NSHA. (2017). Strengthening the Primary Health Care System in Nova Scotia. Evidence synthesis and guiding document for primary care delivery: Collaborative family practice teams and health homes. Nova Scotia: Primary Health Care, Nova Scotia Health Authority. Retrieved February 13, 2018, from http://www.nshealth.ca/sites/nshealth.ca/files/phc_evidence_synthesis_april_2017_final_updated.pdf

Terashima, M., Jones, P., Levy, A., Christian, E., Ahrens, B., Dowling, L., & Traynor, R. (2016). Developing Nova Scotian community clusters for health service planning and research: An inter-sectoral, collaborative approach to the development of community cluster boundaries. Halifax, Nova Scotia:

Maritime SPOR SUPPORT Unit. Retrieved February 13, 2018, from http://www.spor-maritime-srap.ca/sites/default/files/Community%20Cluster%20Report%20-%202017-01-25%20-%20FINAL.pdf

Last Updated: 2018-09-25
Author(s): Catherine Labasi-Sammartino, Noushon Farmanara
Validation: This section was not validated beyond the research team.

Macro Policy Scan: PRINCE EDWARD ISLAND

Part I: Primary Health Care Policy Structure and Scope

1) What is the formal governance structure for primary care (Ministry name, where in the structure is provincial/territorial oversight for primary care)? If possible, include an organizational chart of provincial government department structure, and an organizational chart of the subsidiary branches, departments, or units of the department of health.

The provincial health structure is in accordance with the PEI *Health Services Act*. The PEI health system is comprised of:

The Department of Health and Wellness: is responsible for policy development and administration of publicly funded health services in PEI. It provides oversight to health services in the province in accordance with the *Health Services Act.* It establishes an accountability framework, standards for health services, performance targets, policy or guidelines for the management of operations and delivery of services and approves business plans and budgets (Government of PEI n.d.-a).

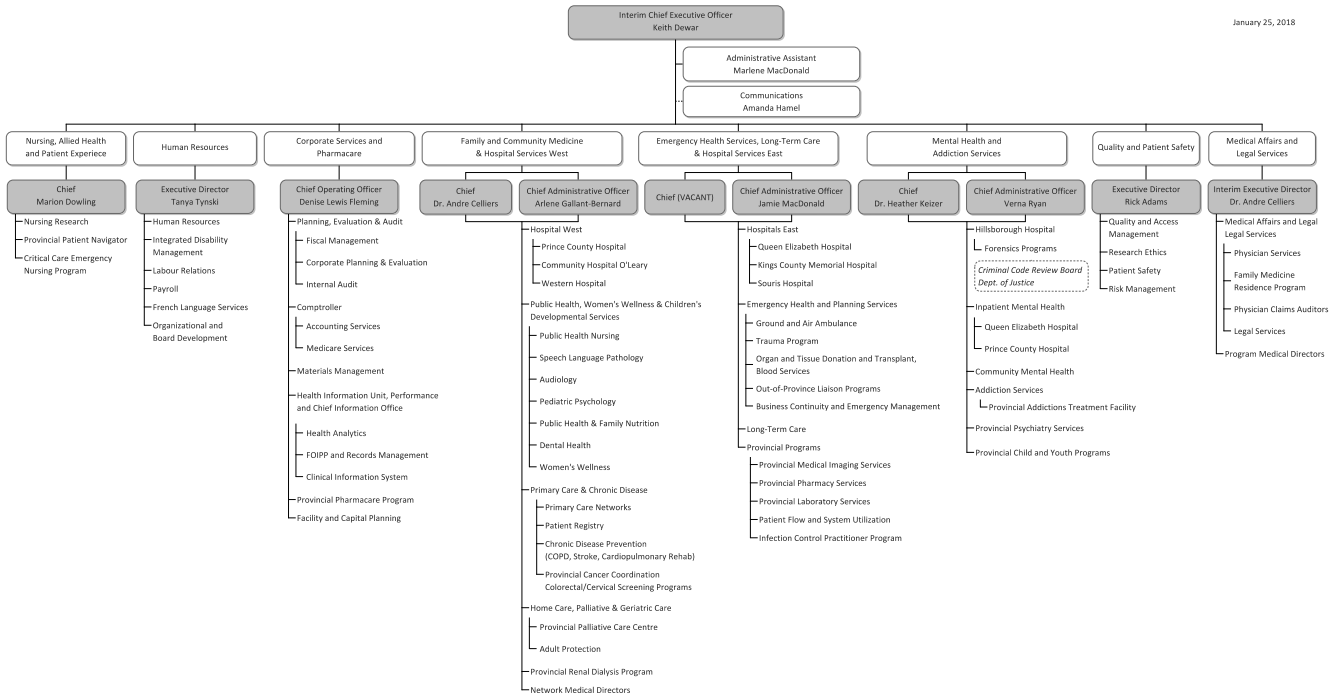
Figure 3.3 Department of Health and Wellness Overview, as of March 2013

Health PEI: an arms-length crown corporation responsible for the day-to-day operational delivery of health services in PEI in accordance with policies set out by the Department of Health and Wellness. Established in 2010, the roles and responsibilities of Health PEI were set out in the province's *Health Services Act*. As dictated in the *Act*, the Minister of Health and Wellness is responsible for determining/distinguishing (through a provincial health plan) the health services to be provided or made available, and the facilities to be operated, by the Minister (i.e., the Department of Health and Wellness) vs. Health PEI. Health PEI was an important step towards realizing a 'One Island Health System'. Its divisions are:

- Nursing, Allied Health and Patient Experience
- Emergency Health Services, Long-Term Care, and Hospital Services East
- Family and Community Medicine, and Hospital Services West
- Mental Health and Addiction Services
- Quality and Patient Safety
- Corporate Services and Pharmacare
- Human Resources

Responsibility for primary care falls under the Primary Care and Chronic Disease section of the Division of Family and Community Medicine, and Hospital Services West within Health PEI (Health PEI n.d.-a).

Figure 2. Health PEI detailed organizational structure, as of Jan. 2018



2) What specific services fall under the same governance structure as primary care? (i.e., scope – home care? Social services? End-of-life support? Any public health functions?)

According to the PEI Health Department, primary care refers to the first point of contact between Islanders and their health system. This includes visits to a family physician or health centre, walk-in clinics, cancer screening programs, chronic disease prevention and management programs, and community-based addictions services. Primary care is intended ultimately to help reduce hospitalizations and visits to the emergency department for Islanders by emphasizing prevention, encouraging healthy habits and teaching effective management of existing health conditions.

Responsibility for primary care falls under the Primary Care and Chronic Disease section, which is also responsible for providing "leadership, management, policy/program development, and services delivery", for the following services:

- Chronic disease prevention and management.
- The Provincial Patient Registry
- 811 Telehealth
- Provincial Insulin Pump Program
- Aboriginal health integration projects.
- Provincial cancer coordination and colorectal/cervical cancer screening.

More broadly, the Family and Community Medicine and Hospital Services West Division (under which the Primary care and Chronic Disease section falls), is responsible for a number of additional services including home care, palliative care, geriatric services, acute care, public health services (e.g., public health nursing, family nutrition, dental public health), and women's wellness and children's developmental services (see Fig.3; Health PEI n.d.-a).

Social services do not fall under the governance of Health PEI nor the Department of Health and Wellness more broadly. Most social services fall under the governance of the Department of Family and Human services, which is responsible for services such as housing programs and social assistance (Government of PEI n.d.-b).

3) Is primary care governance and organization decentralized to the regional structures? What are the entities and scopes of responsibility?

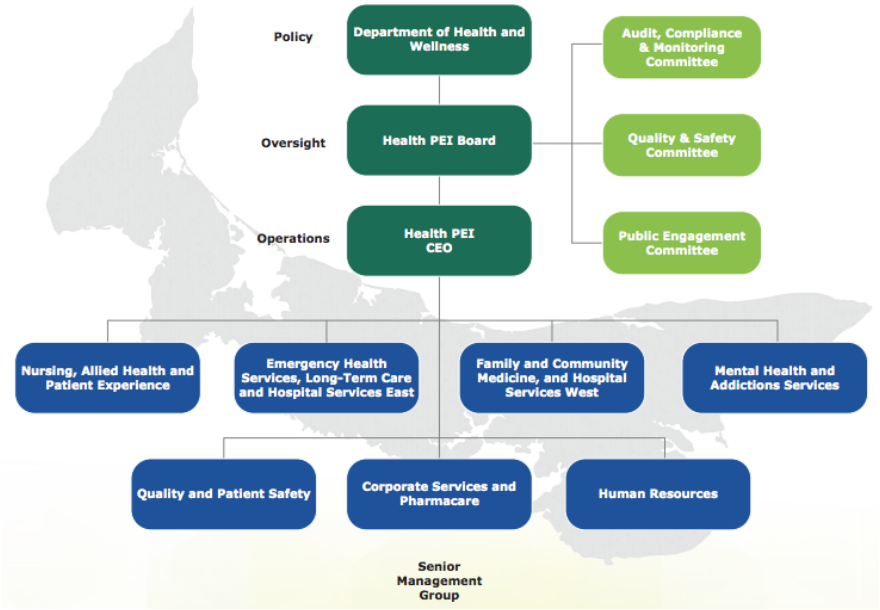
Health PEI is the single health authority for Prince Edward Island. They are responsible for the delivery of publicly funded health services in the province. Health PEI is responsible for the organization of hospitals, health centres, public long-term care nursing facilities, and community-based programs and services (Health PEI n.d.-a).

Health PEI is governed by a Board of Directors that is accountable to the Minister of Health and Wellness. The board manages the delivery of care and oversees the Chief Executive Officer who works with a variety of health care professionals to provide health care services. The Minister of Health and Wellness appoints each board member for a three-year term.

While the Department of Health and Wellness establishes the goals, objectives, and priorities for the provision of health services (such as primary care) in the province, Health PEI is responsible for the organization, operation and delivery of these services.

Last Updated: 2018-09-25
Author(s): Catherine Labasi-Sammartino, Noushon Farmanara
Validation: This section was not validated beyond the research team.

Figure 3. Health PEI high-level organizational structure (2016-2017)

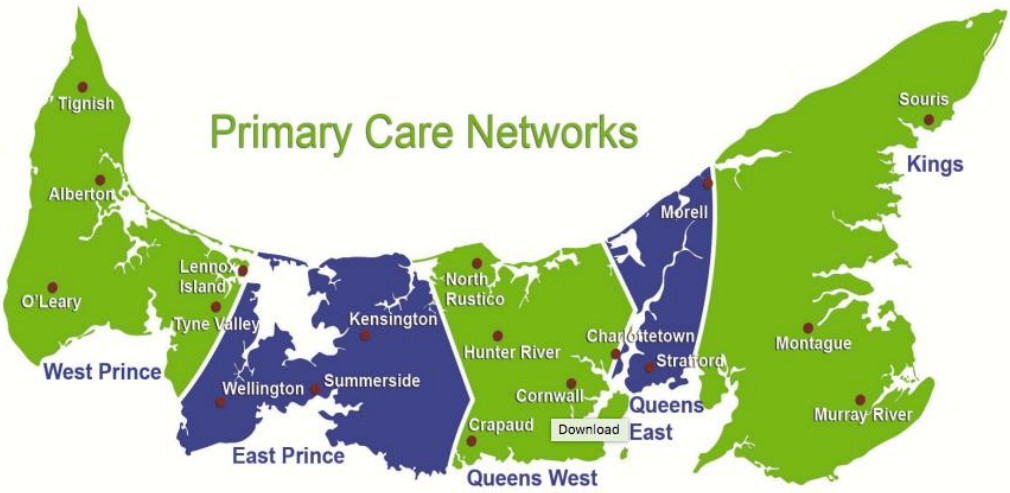


In addition, falling under the governance of Health PEI are five Primary Care Networks spread across the province with health centers in each. The networks are: West Prince, East Prince, Queens West, Queens East, and Kings County. The primary care network approach brings together a variety of care professionals including family physicians, nurse practitioners, registered nurses, diabetes educators, licensed practical nurses, and administrative staff. Some networks also have dietitians and mental health workers (Health PEI 2015). A typical centre includes: Managerial and Administrative Clerical Support, a Medical Director, Nursing Clinical Lead, and a Network Admin Supervisor & Sec/Clerk. The core team typically includes:

- Family Physicians (group of 4 to 8 Family Physicians)
- Nurse Practitioners
- Registered Nurses
- Licensed Practical Nurses
- Diabetes Educators
- Administrative and Clerical Staff

Last Updated: 2018-09-25
Author(s): Catherine Labasi-Sammartino, Noushon Farmanara
Validation: This section was not validated beyond the research team.

Figure 4. *4***Map of Primary Care Networks in PEI**



4) What are the models for delivery of front-line primary care? (e.g., autonomous private delivery, reform models by name, community health centres) What is the approximate proportion and population coverage?

When non-urgent care is needed, family physicians are the most appropriate providers to consult. A Patient Registry Program exists to connect Islanders to a family doctor or nurse practitioner that is accepting new patients. In urgent cases, Islanders are redirected to their community's nearest walk-in clinic. They provide extended days and hours of services made possible by Health PEI's partnership with heath care providers and community pharmacies to offer non-urgent care to Islanders when a family physician is not available. There are nine walk-in clinics across Prince Edward Island.

In addition, each of the five Primary Care Networks previously mentioned have Health Centres, where individuals can access primary care services (Health PEI 2015).

(1) King's Primary Care Network:
- Eastern King's Health Centre
- Montague Health Centre

(2) Queen's East Primary Care Network:
- Polyclinic

(3) Queen's West Primary Care Network:
- Four Neighborhoods Health Centre
- Central Queens Health Centre
- Gulf Shore Health Centre

(4) East Prince Primary Care Network
- Kensington Health Centre
- Harbourside Health Centre
- Evangeline Health Centre

(5) West Prince Health Network
- Tyne Valley Health Centre

- O'Leary Health Centre
- Alberton Health Services

Close to 90 per cent of Prince Edward Island have a regular healthcare provider (Canadian Institute for Health Information 2015).

PEI has also implemented mental health walk-in clinics to offer immediate mental health support to help with anxiety, life events causing stress and other mental health issues. No appointment or referral is required. Clients can meet with a registered mental health therapist who may refer them to Community Mental Health or to specific programs such as the Strongest Families or Behaviour Support Team. Six of these walk-in clinics are available at a variety of locations, such as health centres, hospitals, and high schools (Health PEI 2018).

5) What are the main reform models of primary care and/or primary health care (list & briefly describe)?

Family Health Centres: As part of the provincial/territorial funding envelope for the Primary Health Care Transition fund, PEI undertook their primary health care redesign to strengthen the funding, organization, and delivery of primary health care services in the province. The province undertook five main initiatives, although only three were ultimately implemented. One of the initiatives was the establishment of collaborative Family Health Centres (FHC), with the goal of improving access to comprehensive services and continuity of care through coordinated and integrated care models (Health Canada 2007). Five FHCs were initially established out of the PHCTF. This was eventually extended to six centres operating on the Island (Corpus Sanchez International Consultancy 2008).
In the development of the FHCs, PEI provided conference workshops on interdisciplinary collaborative practice and chronic disease management for all FHC staff. Furthermore, PEI participated in the *Building a Better Tomorrow Initiative* with the other Atlantic provinces, which developed and provided six training models for care providers, focusing on primary health care improvement and collaborative practice. Although a collaborative practice model, observations have been made that the FHC model still relies predominantly on physician visits with some support from registered nurses, although the latter has not been consistently monitored (Corpus Sanchez International Consultancy 2008).

Primary Care Networks: Established in 2011, Primary Care Networks (PCN) were put forward as a renewed model for the delivery of primary care services in PEI. The distribution of the networks ensured similar population sizes and equitable staff/resource allocation across all the networks. Another goal of the PCNs was to ensure that all Islanders were within a 30km radius from a primary care site. PCNs were not a standalone delivery model but rather built on the existing primary care delivery sites within the network, such as private physician clinics and health centres (Health PEI n.d.-b; Health PEI 2015).

Although not reform models themselves, a number of frameworks have outlined the vision for primary care transformation in the province and have served as guiding principles for the reforms above.

Last Updated: 2018-09-25
Author(s): Catherine Labasi-Sammartino, Noushon Farmanara
Validation: This section was not validated beyond the research team.

Health PEI Strategic Plan (2017-2020): Three main objectives have stood out from the most recent strategic plan: quality and safety, access and coordination, and innovation and efficiency. As part of the goal to improve access and coordination to primary care services, the strategic plan highlights the expansion of primary care delivery including same day/next day access and collaborative practice models as a key solution. Reform of the existing patient registry in PEI is another initiative outlined in the strategic plan to improve access to primary care providers (Health PEI 2017).

A Call to Action: A Plan for Change (2008): PEI underwent a comprehensive review of its health system in 2008, culminating in the release of a report entitled, *A Call to Action: A Plan for Change*. The report made recommendations across all sectors of the healthcare system but found serious gaps in the provision of primary care and highlighted a need for primary health care renewal in the province. Among other recommendations, the report called for a need to expand the current human resource model to better incorporate other key health providers such as nurse practitioners as both an individual model of care and integrated into existing family health centres and physician's offices (Corpus Sanchez International Consultancy 2008).

References:

Canadian Institute for Health Information. (2015). Your health system: Have a regular doctor details in PEI. Retrieved from: https://yourhealthsystem.cihi.ca/hsp/indepth?lang=en#/indicator/001/2/C9001/.

Corpus Sanchez International Consultancy. (2008). An Integrated Health System Review in PEI--A Call to Action: A plan for change. Retrieved from https://www.princeedwardisland.ca/sites/default/files/publications/ ihsrcsi08h.pdf.

Government of PEI. (n.d.-a). About: Health and wellness. Retrieved from: https://www.princeedwardisland.ca/en/department/health-and-wellness/about.

Government of PEI (n.d.-b). About: Family and Human Services. Retrieved from: https://www.princeedwardisland.ca/en/department/family-and-human-services/about.

Health Canada. (2007). Primary Health Care Transition Fund: Summary of Initiatives, Final Edition. Ottawa: Health Canada. Retrieved from: https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/hcs-sss/alt_formats/hpb-dgps/pdf/phctf-fassp-initiatives-eng.pdf

Health PEI. (n.d.-a). About: Health PEI. Retrieved from: https://www.princeedwardisland.ca/en/department/health-pei/about.

Health PEI. (n.d.- b). Primary (Health) Care: Current Programs and Services. Retrieved from: https://www.princeedwardisland.ca/sites/default/files/publications/primary_health_care_-_current_programs_and_services.pdf.

Health PEI. (2015). Health Centres Offer Primary Care. Retrieved from: https://www.princeedwardisland.ca/en/information/health-pei/health-centres-offer-primary-care.

Last Updated: 2018-09-25
Author(s): Catherine Labasi-Sammartino, Noushon Farmanara
Validation: This section was not validated beyond the research team.

Health PEI. (2017). Strategic Plan: 2017-2020. Retrieved from: https://www.princeedwardisland.ca/sites/default/files/publications/health_pei_strategic_plan_2017-2020.pdf.

Health PEI. (2018). Mental Health Walk-in Clinics. Retrieved from: https://www.princeedwardisland.ca/en/information/health-pei/mental-health-walk-clinics.
Health Services Act, 2015, c. H-1.6.

Last updated: 2018-09-24
Author(s): Laura Lee Madden
Validation: Kevin Chan, Kris Aubrey, Cassie Chisholm, Cameron Campbell

Macro Policy Scan: NEWFOUNDLAND AND LABRADOR

Part I: Primary Health Care Policy Structure and Scope

1) What is the formal governance structure for primary care (Ministry name, where in the structure is provincial/territorial oversight for primary care). If possible, include an organizational chart of provincial government department structure, and an organizational chart of the subsidiary branches, departments, or units of the department of health.

The Newfoundland and Labrador government consists of 13 departments, one of which is Health and Community Services (gov.nl.ca, n.d.). Located within the department of Health and Community Services, the Primary Health Care (PHC) Division is situated within the Population Health Branch. The PHC division sets the policy direction for PHC service delivery across the province, which is implemented by the regional health authorities (RHA) and the Newfoundland and Labrador Centre for Health Information.

- Advanced education, skills and labour
- Children, seniors and social development
- Education and early childhood development
- Executive council
- Finance
- Fisheries and land resources
- Health and community services
- Justice and public safety
- Municipal affairs and environment
- Natural resources
- Service NL
- Tourism, culture, industry and innovation
- Transportation and works

Primary health care in Newfoundland is considered to be interdepartmental. While the Department of Health and Community Services holds primary responsibility, all provincial government entities are expected to consider the impact their decisions have on the health and well-being of the residents of Newfoundland (as part of the “Health in All” policy) (health.gov.nl.ca, 2015).

The Department of Health and Community Services leads the program development, policy, planning and support of mandated community service and health agencies, including the four regional health authorities (health.gov.nl.ca, 2017). It also evaluates and provides feedback to the four health authorities regarding accountability issues, program implementation, and community and health outcomes (health.gov.nl.ca, 2017). The department also represents the health interests of Newfoundlanders and Labradorians in intergovernmental initiatives and discussions and ensures that best practices, guidelines, and standards are used to benefit residents of Newfoundland and Labrador

(health.gov.nl.ca, 2017). The PHC Division has formalized linkages with each RHA for PHC program strategy and operations. There is a PHC Leadership Council and a PHC Management Committee with representation from the RHAs and other stakeholders. The Regional Health Authorities have Departments of Primary Healthcare which are responsible for programs at the RHA level.

2) What specific services fall under the same governance structure as primary care? (i.e., scope – home care? Social services? End-of-life support? Any public health functions?)

The Department of Health and Community Services is made up of the following branches and divisions. It is relevant to note that RHAs have offices where most of the PHC activities are administered (health.gov.nl.ca, 2017).

- Executive branch
    - Communications
- Corporate services branch
    - Financial services
    - Audit and claims integrity
    - Information management
    - Strategic human resources
    - Pharmaceutical services
- Medical services branch
    - Physician services
    - Dental services
    - Pathology and laboratory services
- Regional services branch
    - Infrastructure management
    - Acute health services and nursing policy
    - Long-term care and community support services
- Policy, planning and performance monitoring branch
    - Government relations
    - Policy and legislative affairs
    - Planning and evaluation
    - Health workforce planning
- Population health branch
    - Communicable disease control
    - Environmental public health
    - Health emergency management
    - Mental health and addiction
    - Primary Health Care
        - Air and Ground Ambulance Services

It is relevant to note that physician services are housed under the medical services branch, and Primary Health Care is housed under the Population Health branch. The Medical Services Branch is responsible

for the provision of dental, pharmaceutical, and medical services (practicenl.ca, n.d.). The Physician Services Division within the Medical Services Branch is responsible for the development and maintenance of insured medical service programs. Responsibilities also include the development and implementation of guidelines and procedures for both salaried, fee-for-service and alternate pay physicians and involve negotiations with the Newfoundland and Labrador Medical Association (NLMA; health.gov.nl.ca, 2018).

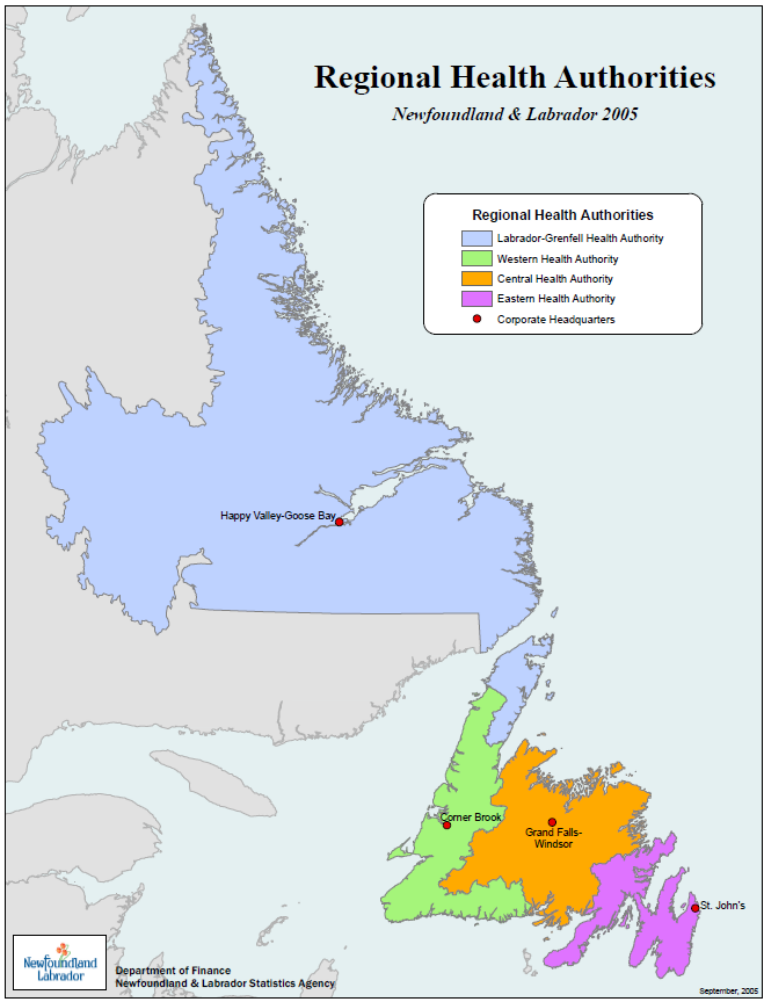
The Department of Health and Community Services offers the following services, which are administered by the four RHAs (health.gov.nl.ca, 2017):

- Acute care hospital services
- Long term care services
- Community based services
    - Health promotion
    - Community correction
    - Health protection
    - Childcare services
    - Mental health and addictions services
    - Intervention services
    - Community support program
    - Residential services
    - Community health nursing services
    - Satellite renal dialysis services
    - Medical clinics
    - Community clinics

3) Is primary care governance and organization decentralized to the regional structures? What are the entities and scopes of responsibility?

Publicly funded health and community services are delivered across Newfoundland and Labrador by four regional health authorities: Eastern, Central, Western, and Labrador-Grenfell (health.gov.nl.ca, 2017). These four health authorities were established in 2005.

Last updated: 2018-09-24
Author(s): Laura Lee Madden
Validation: Kevin Chan, Kris Aubrey, Cassie Chisholm, Cameron Campbell



(stats.gov.nl.ca, 2005)

Eastern Regional Health Authority serves a regional population of greater than 290,000 (practicenl.ca, n.d.). It offers full health care services, including acute care, long-term care, community health services, and province-wide tertiary care (practicenl.ca, n.d.).

Central Regional Health Authority is the result of the 2005 merger of the Central East Health Care Institutions Board, Central West Health Corporation and Health and Community Services – Central (practicenl.ca, n.d.). It serves a regional population of approximately 94,000 and is responsible for the administration and delivery of health and community services in its region (practicenl.ca, n.d.). Central Health provides primary health care, secondary acute care, long-term care, and community-based programs (practicenl.ca, n.d.). Community based services include health promotion, mental health and addictions services, health protection, community corrections, childcare services, child, youth, and family services, community support programs, community health nursing services, and intervention services (practicenl.ca, n.d.).

Western Regional Health Authority is the result of the 2005 merger of Western Health Care Corporation and Health and Community Services Western (practicenl.ca, n.d.). It is responsible for the governance and delivery of health and community programs and services and serves 82,000 Newfoundland residents (practicenl.ca, n.d.). Western Health provides primary health care, secondary acute care, long term care, adult rehabilitation services, and community-based programs (practicenl.ca, n.d.). Community based programs include mental health and addiction services, health protection, health promotion, community corrections, community support programs, child, youth, and family, childcare, community health nursing, and intervention (practicenl.ca, n.d.). At Western Health, primary care services encompass management and prevention of chronic injuries and diseases, the promotion of wellness, referrals to other health services, and the initial care, treatment, and follow-up of numerous health conditions and injuries (westernhealth.ca, 2016). Primary care is provided by family doctors, allied health professionals, nurse practitioners, and community health nurses (westernhealth.ca, 2016).

Labrador-Grenfell Regional Health Authority is the result of the 2005 merger of Grenfell Regional Health Services and Health Labrador Corporation (practicenl.ca, n.d.). It serves a population of 37,000 Newfoundland residents and provides primary and secondary health services including acute care, continuing and long-term care, diagnostic services, mental health and addictions services, health promotion, family and rehabilitation services, youth services, adoptions, child protection and intervention services, child care services, community health nursing, and residential services (practicenl.ca, n.d.).

4) What are the main models for delivery of front-line primary care? (e.g., autonomous private delivery, reform models by name, community health centres) What is the approximate proportion and population coverage?

Primary care is delivered by physicians either in an independent practice at a private clinic or within a health authority (practicenl.ca, n.d.). Reform efforts are underway in the province to provide PHC under the Health Home model. This draws from the Patient's Medical Home model from the College of Family Physicians of Canada (2011) but is adapted to the provincial context with strong emphasis on fully leveraging the scope of practice of collaborating interprofessional teams. (Personal communication, 2018).

Fee-for-service (FFS): most urban doctors and approximately 50% of rural physicians operate under a fee-for-service model, whereby physicians receive payments for each service he/she performs (ag.gov.nl.ca, 2014). Approximately 80% of the population is covered by FFS physicians.

Salaried: Approximately 50% of rural physicians operate under a salaried compensation model. These physicians are employed by the respective RHA and receive a set salary based on the Memorandum of Agreement made between the Newfoundland and Labrador Medical Association and Government (ag.gov.nl.ca, 2014). Approximately 20% of the population is covered by salaried physicians.

Alternate payment plans also exist, which combine elements of both fee-for-service and salary methods, Physicians receives payments by individual contracts that are based on block funding arrangements (ag.gov.nl.ca, 2014). It is primarily specialists that operate under this compensation model.

Primary Healthcare Demonstration Sites: As part of a commitment to improve primary healthcare in the province, the Government of Newfoundland and Labrador announced a commitment to expand primary health care teams throughout the province. (gov.nl.ca, Expand Primary Health Care Teams, n.d.) Demonstration sites were established in Bonavista and on the Burin Peninsula in 2017. Additional sites are under consideration or in early days of implementation. These local primary health care teams are interdisciplinary, with a focus on improvement of chronic disease management and coordination of care across public health, home and community supports, and mental health and addictions. (gov.nl.ca, Expand Primary Health Care Teams, n.d.; gov.nl.ca, 2018)

- The Primary Health Care Team on the Burin Peninsula consists of a wide variety of stakeholders including schools, churches, community leaders, and people with lived experience. Frontline healthcare providers such as nurses, social workers, physicians, paramedics, psychiatrists and managers from a variety of program areas like primary health care, mental health and addictions, and emergency services. (gov.nl.ca, 2018)
    - In a relatively short period, outcomes have included eliminated wait lists for mental health and addictions counselling services and no-show/cancellation of appointments. Improvements have also been made in enabling access to same-day, walk-in services.
- In Bonavista, the primary health care team is similarly comprised by a variety of providers (i.e., physicians, nurses, diabetes educator, pharmacist, physiotherapist, occupational therapist, public health nurse, and social worker). Similar improvements in shortened wait times and better chronic disease management have been noted within the practice. (Packet, 2018)

5) What are the main reform models of primary care/primary health care (list & briefly describe)?

Primary Health Care Teams: A primary objective of the renewed framework for primary health care in Newfoundland and Labrador was improving attachment of individuals and families to a collaborative primary health care team that include a variety of providers aligned to meet the needs of the communities they serve. (gov.nl.ca, 2015) Demonstration sites were established in 2017 in Bonavista and the Burin Peninsula. These Primary health care teams are interdisciplinary, with a focus on improvement of chronic disease management and coordination of care across public health, home and community supports, and mental health and addictions. (gov.nl.ca, Expand Primary Health Care Teams, n.d.; gov.nl.ca, 2018)

Health Home Model: Reform efforts are underway in Newfoundland & Labrador to provide PHC under the Health Home model. This draws from the Patient's Medical Home model by the College of Family Physicians Canada but is adapted to the provincial context with a strong emphasis on fully leveraging the scope of practice of collaborating interprofessional teams. The objective of the 'Health Homes' will be to provide a central hub where individuals and families can access a range of services and supports, that would include primary health care services as well as connections to other health and social supports

(health.gov.nl.ca, 2015). At the time of data collection, a discussion paper describing the model is being drafted.

Family Practice Renewal Program (FPRP): Other reform initiatives are being developed by the FPRP. Originally, the Primary Care Renewal Program, the FPRP's mission is "to transform family practice for better health" (nlma.nl.ca, n.d.). The FPRP recognizes that a renewed focus on family practice reform and primary health care reform is necessary to improve health system sustainability and population health (familypracticerenewalnl.ca, 2018). They endorse the following principles: access to appropriate services and supports, attachment and longitudinal relationships, collaborative interdisciplinary teams, communities of practice, community engagement and a local focus, coordination of care, comprehensiveness of care, continuous evaluation and evidence-based decision making, and patient-centered services and supports (familypracticerenewalnl.ca, 2018). FPRP is governed jointly by the Department of Health and Community Services and the Newfoundland and Labrador Medical Association (nlma.nl.ca, n.d.). The FPRP is voluntary and has three core initiatives:

Family Practice Networks: This initiative will allow physician groups to work in collaboration with regional health authorities to address local population health needs and common practice needs (but not currently implemented; familypracticerenewalnl.ca, 2018). Two FPN were formed in early 2018: Shalloway FPN and Long Range FPN, that represent participating physicians in Central and Western Newfoundland respectively.

Fee Code Program (only telephone codes presently): This program enhances the fee-for-service schedule, designed to improve health system, physician, and patient benefits such as improvements in patient access, collaboration with other providers, comprehensive care, and a practice improvement program (familypracticerenewalnl.ca, 2018). Two new fee codes are to be rolled out in 2018: Patient Care Telephone Code and Share Care Code. These fee codes will compensate physicians for telephone communication/consultation with patients and for collaborative conferencing between physicians and other healthcare providers in developing patient care plans, respectively. Other potential billing codes are pending.

Practice Improvement Program: This program will provide education and support for workflow and clinical issues to physician practices (familypracticerenewalnl.ca, 2018). The Practice Improvement Program will be intended to provide physicians with professional support in addressing practice efficiency needs, reducing wait times, building team-based skills, implementing guideline-based care, etc. In addition, practice support will be available to help physicians take advantage of integrating new fee codes into their practice workflow. Program development is underway.

Although not reform models themselves, a number of frameworks have outlined the vision for primary health care transformation in the province and have served as the guiding principles for many of the present and future reforms above.

A Primary Health Care Framework for Newfoundland and Labrador 2015-2025: In 2015, a collaboration of departments including the departments of Health and Community Services, Child Youth and Family

Services, Education and Early Childhood Development, Service NL, Seniors Wellness and Social Development, Advanced Education and Skills, Office of Public Engagement, and the Women's Policy Office developed a new primary health care framework entitled Healthy People, Health Families, Healthy Communities: a Primary Health Care Framework for Newfoundland and Labrador 2015-2025 (health.gov.nl.ca, 2015). A new primary health care reform was considered necessary to address issues specific to health care provider retention, the aging population of Newfoundland and Labrador, growing health care costs, and the need to incorporate evidence-based health promotion and prevention, with the ultimate goal of improving population health (health.gov.nl.ca, 2015). This framework identified four goals with underlying objectives as crucial to the improvement of primary health care in Newfoundland and Labrador:

- Goal 1: Engaged individuals, families, and communities sharing responsibility for health promotion and illness and injury prevention, early intervention, and self-management.
- Goal 2: Individuals and families attached to a collaborative primary health care team.
- Goal 3: Timely access to comprehensive, person-focused primary health care services and supports.
- Goal 4: Connected and coordinated services and supports across the health and social sectors.

Moving Forward Together: Mobilizing Primary Health Care (2003): This earlier primary health care framework outlined the Department of Health and Community Services' view for a provincial primary health care model for Newfoundland and Labrador (health.gov.nl.ca, 2003). The framework asserted 16 principles for the renewal of primary health care; notably, that

- Teams and networks of health professionals will work in partnership with patients/clients to provide a continuum of services including health promotion, illness prevention, health protection, emergency transportation, management of acute and chronic diseases, rehabilitation, and end of life care;
- Primary health care teams will have established linkages with health and community services programs, and secondary and tertiary health services to support a continuum of service and care delivery;
- Primary health care teams will adopt a population-based, community development and intersectoral approach to health services planning, implementation, and evaluation; and
- Economic, social, and cultural determinants of health will be recognized and reflected in primary health care services (health.gov.nl.ca, 2003, pp. 4-5).

References:

ag.gov.nl.ca. (2014). *Fee-For-Service Physicians: Audit Process.* Auditor General of Newfoundland and Labrador. Retrieved February 13, 2018, from http://www.ag.gov.nl.ca/ag/annualReports/2013AnnualReport/3.2%20%20Fee-For-Service-Physicians%20Audit%20Process.pdf

College of Family Physicians of Canada (2011). *A Vision for Canada: Family Practice - The Patient's Medical Home.* CFPC.

familypracticerenewalnl.ca. (2018). *About*. Retrieved February 13, 2018, from Family Practice Renewal Program: http://familypracticerenewalnl.ca/about/

gov.nl.ca. (2015). *Healthy People, Healthy Families, Healthy Communities: a Primary Health Care Framework for Newfoundland and Labrador 2015-2025.* Government of Newfoundland and Labrador.

gov.nl.ca. (2018, July 30). *Primary Health Care Team Creating Positive Change on the Burin Peninsula*. Retrieved from https://www.releases.gov.nl.ca/releases/2018/health/0730n03.aspx

gov.nl.ca. (n.d.). *Department and Agencies*. Retrieved February 13, 2018, from Newfoundland Labrador: https://www.gov.nl.ca/departments/

gov.nl.ca. (n.d.). *Expand Primary Health Care Teams*. Retrieved from https://www.gov.nl.ca/thewayforward/action/expand-primary-health-care-teams/

health.gov.nl.ca. (2003). *Moving Forward Together: Mobilizing Primary Health Care - A Framework for Primary Health Care Renewal in Newfoundland and Labrador.* Newfoundland Labrador, Department of Health & Community Services. Partnering For Health. Retrieved February 13, 2018, from http://www.health.gov.nl.ca/health/publications/moving_forward_together_apple.pdf

health.gov.nl.ca. (2015). *Healthy People, Healthy Families, Healthy Communities: A Primary Health Care Framework for Newfoundland and Labrador 2015-2025.* Newfoundland Labrador. Retrieved February 13, 2018, from http://www.health.gov.nl.ca/health/publications/PHC_Framework_update_Nov26.pdf

health.gov.nl.ca. (2017, May 9). *Health and Commnunity Services - Branches and Divisions*. Retrieved February 13, 2018, from Newfoundland Labrador: http://www.health.gov.nl.ca/health/department/branches/index.html

health.gov.nl.ca. (2017, May 9). *Health and Community Services - About the Department*. Retrieved February 13, 2018, from Newfoundland Labrador: http://www.health.gov.nl.ca/health/department/index.html

health.gov.nl.ca. (2017, May 9). *Health and Community Services - Services in Your Region*. Retrieved February 13, 2018, from Newfoundland Labrador: http://www.health.gov.nl.ca/health/findhealthservices/in_your_community.html

health.gov.nl.ca. (2018, July 4). *Physician Services Branch*. Retrieved from https://www.health.gov.nl.ca/health/department/branches/divisions/div_physicianserv.html

nlma.nl.ca. (n.d.). *Notices & Advisories: Primary Care Renewal Program Re-branded*. Retrieved February 13, 2018, from Newfoundland and Labrador Medical Association: http://www.nlma.nl.ca/News-And-Events/Notices-And-Advisories/Page/0/Article/352

Packet, T. (2018, August 24). *Bonavista Peninsula benefiting from new approach to primary health care*. Retrieved from https://www.thepacket.ca/news/local/bonavista-peninsula-benefiting-from-new-approach-to-primary-health-care-236326/

Personal communication. (2018, May 23).

practicenl.ca. (n.d.). *Room to Grow - About our Health Care System*. Retrieved February 13, 2018, from Practice Newfoundland Labrador: https://www.practicenl.ca/?/roomtogrow_abouthealthcare.asp

practicenl.ca. (n.d.). *Room to Grow - Types of Practice*. Retrieved February 13, 2018, from Practice Newfoundland Labrador: https://www.practicenl.ca/?/roomtogrow_typesofpractice.asp

practicenl.ca. (n.d.). *Welcome to Central Regional Health Authority - Overview of the Central Health Region*. Retrieved February 13, 2018, from Practice Newfoundland Labrador: https://www.practicenl.ca/?/central_overview.asp

practicenl.ca. (n.d.). *Welcome to Eastern Regional Health Authority - About Eastern Health*. Retrieved February 13, 2018, from Practice Newfoundland Labrador: https://www.practicenl.ca/?/east_about.asp

practicenl.ca. (n.d.). *Welcome to Labrador-Grenfell Regional Health Authority - About Labrador-Grenfell Health*. Retrieved February 13, 2018, from Practice Newfoundland Labrador: https://www.practicenl.ca/?/lab_about.asp

practicenl.ca. (n.d.). *Welcome to Western Regional Health Authority - Overview of the Western Health Region*. Retrieved February 13, 2018, from Practice Newfoundland Labrador: https://www.practicenl.ca/?/west_overview.asp

stats.gov.nl.ca. (2005, September). *Regional Health Authorities Newfoundland & Labrador 2005*. Retrieved February 13, 2018, from Newfoundland Labrador: http://www.stats.gov.nl.ca/Maps/pdfs/HA_NL.pdf

westernhealth.ca. (2016). *Medical Clinics (Primary Care)*. Retrieved February 13, 2018, from Western Health: http://westernhealth.nl.ca/home/locations/locations-2/medical-clinics/

westernhealth.nl.ca. (2016). *Medicine Service*. Retrieved February 13, 2018, from Western Health: http://westernhealth.nl.ca/home/health-topics-main/medicine-service/

Macro Policy Scan: Data Collection Template

INSERT PROVINCE NAME

Part I: Primary Health Care Policy Structure and Scope

1) What is the formal governance structure for primary medical care (Ministry name, where in the structure is provincial/territorial oversight for primary medical care)? If possible, include an organizational chart of provincial government department structure, and an organizational chart of the subsidiary branches, departments, or units of the department of health.
Insert text here.

2) What specific services fall under the same governance structure as primary medical care? (i.e., scope – home care? Social services? End-of-life support? Any public health functions?)
Insert text here.

3) Is primary medical care governance and organization decentralized to the regional structures? What are the entities and scopes of responsibility?
Insert text here.

4) What are the main models for delivery of front line primary medical care? (e.g., autonomous private delivery, reform models by name, community health centres) What is the approximate proportion and population coverage?
Insert text here.

5) Primary care renewal models

- **a) What are the main renewal models of primary (medical) care (list & briefly describe)?**
- **b) What is the approximate proportion and population coverage of all the models for delivery of front line primary medical care? (e.g., autonomous private delivery, reform models by name, community health centres)**
- **c) What is the formal governance structure for primary health care (Ministry name, where in the structure is provincial/territorial oversight for primary health care).**
- **d) Is primary care governance and organization decentralized to the regional structures? What are the entities and scopes of responsibility?**
- **e) What is the accountability agreement of primary medical care reform models providers to ministries of health?**
- **f) Is there a mandate for service coordination of primary care renewal models with other structures?**

Insert text here.

Part II: Governance of Consensus Priority Structures and Link to Primary Care

Obtain a 2018 organizational chart of provincial government department structure, and an organizational chart of the subsidiary branches, departments, or units of the provincial ministry of health.

Locate each of the Priority services in the ministry of health organigram or relevant government structure. If the location is not obvious, find an approximate match by comparing the description of the priority service with the most relevant state mandate of the most proximal governance unit.

6) Are the following services under the same governance hierarchy as primary medical care? (If not, indicate governing authority in the table below).

Priority Service (consolidated list)	**What is governing authority? if in ministry of health, include specific location within organigram.**	**Same governance hierarchy as Primary Medical Care?**
Home Care		
Respite Care		
Palliative Care		
Mental Health Care and Addictions Services		
Linkage of Urgent Emergency & Acute Care		
Navigational Services // Patient Navigators		
Health Education, Healthy Living & Disease Prevention Programs and Services		
Services to Address the Social Determinants of Health (Material Deprivation) • Housing Programs • Community Nutrition Services • Transportation Services Labour, Employment, and Income Services		

Priority Service (consolidated list)	What is governing authority? if in ministry of health, include specific location within organigram.	Same governance hierarchy as Primary Medical Care?
Services to Address the Social Determinants of Health (Social Deprivation) • Community and Recreational Activities • Adult Day Programs Outreach programs to identify marginalized people or people with a limited support network		
Medication Reconciliation Programs in Community Pharmacy		
Chronic Disease Management Programs and/or Services		
Telehealth & Health Information Systems		
Pre-Post Natal Care		
Education Support Programs & Services		