# Characteristics of Primary Care Settings That Succeed in Achieving High Quality of Care

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# Background

- «*PHC in Canada has entered a period of potentially transformative change*»[1]
- Characteristics of key initiatives
  - Interprofessional teams
  - Group practices & networks
  - Patient enrollment with PC provider
  - Financial incentives & blended reimbursement
  - New governance models
  - IT and quality improvement support

*Hutchison B et al., Primary Health Care in Canada: Systems in Motion, Milkbank Quaterly, 2011;89:256-88*

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## Are new models more effective?

- Alberta (PC Networks) (Manns BJ et al., CMAJ 2012)
  - Better diabetes care in patients enrolled in PC Networks (20% less hospitalizations et 20% more opht. care)
- British Columbia *(Full Service Family Practice Incentive Program)* (Hollander, Health care Quaterly 2009)
  - Increased affiliation; hospital costs 5 900$ vs 16 900$ in patients followed in practices in the program



## Are new models more effective?

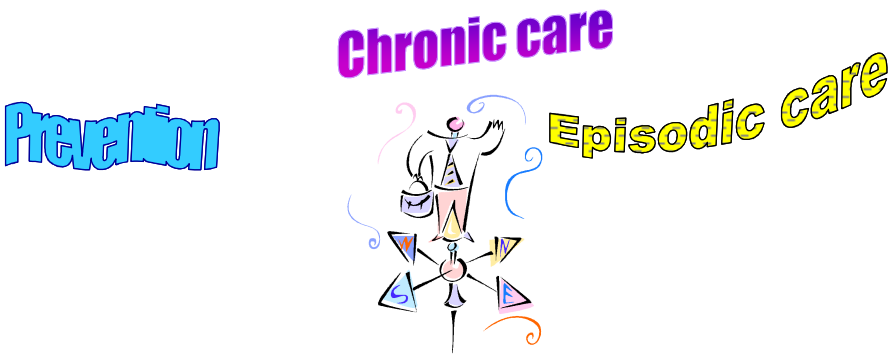
- Ontario (CHC, FFS, FHG, FHN, HSO):
  - Chronic care (Russel, Dahrouge, Hogg et al. Ann Fam Med 2009)
    - Superior in CHCs
    - NP (+), panel size>2 000 (-) and > 4 FTE mds(-)
  - Prevention (Dahrouge, Hogg, Russel et al, CMAJ 2011)
    - no clear impact of models
    - Panel size <1 600, presence of female FPs, electronic reminders
  - Access (Glazier et al. 2009)
    - Less after-hours care & more ER visits in capitation models

# …to summarize

- Some primary care organizational models may perform better than others – none is perfect
  - Tensions between access and quality of care
- Different mix of characteristics per model
  - What are the key characteristics that matter?
- Research has focused on structures rather than processes
  - Processes can explain between and within model variations in quality of care



# The challenges of primary care

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# Research questions

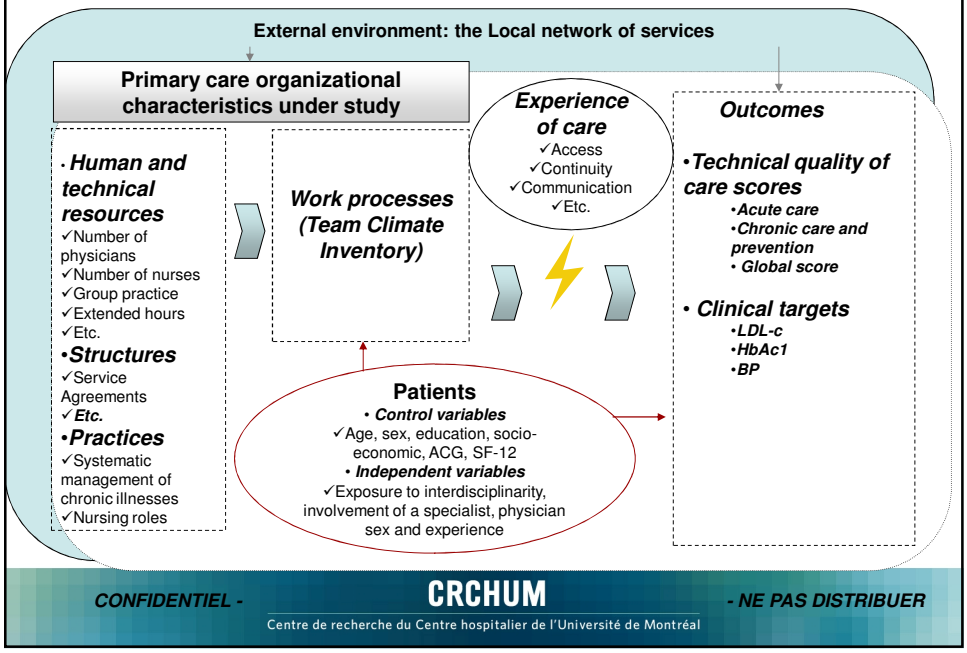
1. Are there organizational characteristics associated with higher quality of care that transcend PC settings models?
   - Contribution of processes vs structures
2. Are some characteristics specific to episodic care vs chronic illness care or prevention ?



# PC settings in Québec

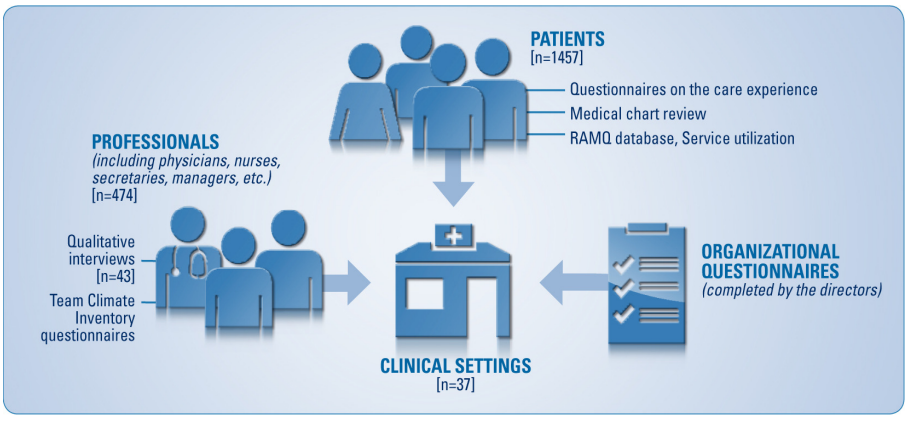
| | CLSCs | FMGs | Traditional |
|---|---|---|---|
| **Governance** | Community | Professional | Professional |
| **Contract RH** | No | Yes | No |
| **Pt enrollement** | No, population | Yes | Yes |
| **Team care** (nurses) | Not dedicated | Dedicated | No |
| **Remuneration** | Salary | Salary/FFS + incentives | FFS + incentives |

# Analytical Framework





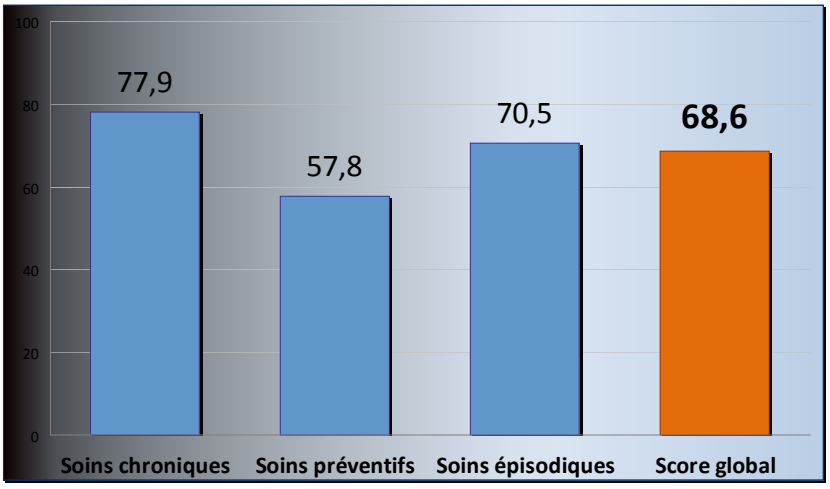

# Data sources



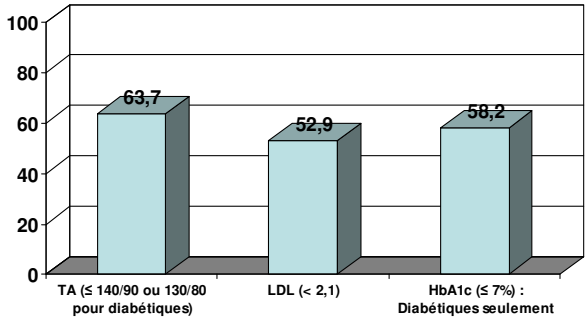
# RESULTS



# Technical Quality of Care Scores



# Targets achieved




| | |
|---|---|
| **Cibles atteintes : nombre (%)** | |
| TA (≤ 140/90 ou 130/80 pour diabétiques) | **549 (63.7%)** |
| Cholestérol LDL (< 2,1) | **440 (52.9%)** |
| HbA1c (≤ 7%) : Diabétiques seulement | **341 (58.2%)** |



# Key finding # 1

- Organizational characteristics explain an important proportion of the TQC scores:
  - 17% of the global TQC
  - 15% of the acute TQC
  - 25% of the Chronic Care & Prevention TQC

*We are first to report a contribution of this magnitude*

## Impact of structural characteristics

- Salary remuneration is the strongest structural predictor of the global TQC score (23 points) and duration of visits (30 min) of the Chronic Care & Prevention TQC score (15 points)

*Other structural characteristics were number of FPs (7-10) and the presence of other professionals and specialists on the premices*

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## Key finding # 2

- The most successful settings are those that value comprehensive primary care and manage their ressources accordingly (internal coherence)

*ie: not only continuity of care and chronic illness care, but also access to care and their capacity to respond appropriately to all types of health problems, wether chronic or episodic*

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# How do they succeed ?

- Crucial role of group processes and of the leadership of the physician manager to foster a common vision of quality and management of resources accordingly
  - Group practice (shared among physicians)
  - Team climate (common objectives, task orientation, communication, support of innovation)
  - Continuing professional education as a team
  - Managing appointment schedules to response to urgent or immediate needs



# How do they succeed?

- Roles of nurses
  - Exposure to interdisciplinary care has a modest impact on Chronic Care & Prevention TQC (3 points)
  - Diversity of roles for nurses in the clinic has a positive impact on organizational accessibility

# Key finding #3

- Organizational accessibility – *as defined by the capacity to reach the clinic by phone, talk to a PC provider for advice and obtain an appointment in a reasonable delay-* is associated with Global and Chronic Care & Prevention TQC scores *(5 points per 10% increase of OA)*

*We are first to report that organizational access is a predictor of TQC*



# Key finding #4

- Finding balance:
  - No unique model in terms of structures– the quality observed is the result of trade-offs to aligne available resources to the common vision of quality
  - Dilemna between populational accessibility and quality of care
  - Less autonomy to manage resources in community oriented models and FMGs

# Implications for policy-making



# Main messages

- Innovations targeting only care for chronic conditions rather than comprehensive primary care may play disservice to the clientele most in needs as well as jeopardizing overall quality of care

- Leadership development and support of efficient team processes (involvement of professionals & staff) are more likely to produce results than the sole modification of structures



# Caveats/limitations

- No estimate of panel size:
  - Technical quality of care vs productivity ?
- Caution in the interpretation of the impact of salary remuneration as predictor of quality in the light of:
  - Absence of true blended remuneration schemes in Québec
  - High nurses\physicians ratio that do not permit optimal complementarity

## Which model is more likely to support effective primary care?

| *Chronic Care Model* | *Medical Home* |
|---|---|
| | Affiliation to a PC provider |
| Financing and remuneration | Financing and remuneration |
| Community resources | |
| Work organization (team care, coordination) | Team care |
| | Coordination et integration |
| Decision support | Quality and security |
| Information system | |
| Fostering self-care | |
| | Comprehensiveness |
| | Efficient and timely access |