MacEachen
INDEPENDENT. INFORMED.

DALHOUSIE UNIVERSITY
FACULTY OF MEDICINE

Roundtable with Health Leaders

Expanding access to family health services

July 2023

Purpose of the Note

The MacEachen Institute for Public Policy and Governance (MIPP) and Dalhousie University Faculty of Medicine hosted a roundtable on June 9, 2023 with invited participants immediately following the closing ceremony of the Fear Memorial Conference on Catalyzing Health Systems Change. The MIPP serves as a forum for vibrant public policy discussion and analysis. The Faculty of Medicine has a strategic goal to catalyze systems change to improve health outcomes.

This roundtable session was an opportunity for system partners and academics to discuss goals for and challenges with expanding access to family services across Atlantic Canada. The 20 participants included professionals in the fields of public health, family medicine, social work, psychiatry and psychology, and government officials.

The roundtable was facilitated by Professor Jim Barker, Professor and Herbert S. Lamb Chair in Business Education at Dalhousie University. A note-taker, Elise Sammons, summarized the discussion and produced this briefing note.

Facilitator

Professor Jim Barker, Herbert S. Lamb Chair in Business Education at Dalhousie University.

Author and Notetaker

Elise Sammons

For more information, email: mipp@dal.ca

Selected Observations and Key Messages

- Every Atlantic Canadian who wants it should have access to the family health services that they need for their wellness and care. Those services need to be culturally safe and meet the needs of all communities including rural communities, Indigenous communities, and other underserved communities.
- There is a move underway toward a collaborative model of care that would see Atlantic Canadians connected to a collaborative care team who would provide ongoing primary care. However, we face many challenges as we transition away from the model of everyone having a family physician and toward everyone having a collaborative care team, or what is sometimes called a health home, as their primary care provider.
- Making the move toward collaborative care models will require us to allow all health providers to work to their full scope of practice. This will require education and a cultural shift. Health care providers will need to be better informed about the scopes of practice of other health care providers.
- Health care providers will also need a variety of tools to ensure high quality care in this collaborative care model, such as access to electronic health records and virtual care tools that include consultations between primary care providers and specialists.
- Policy changes are needed to adopt the collaborative care model and to ensure that systems such as billing codes are set up to support this form of care. There is also a need for public engagement, and for a public information campaign to ensure patients are consulted and well informed.

What We Discussed

What are the medium-term goals (three- to five-years) we are trying to achieve in this policy area?

The main policy goal is for every Atlantic Canadian to have access to the family health services that they need for their wellness and care. It was noted that this likely will not mean that everyone has a family physician. Some patients are not looking for an attachment to a family physician, and there is a significant movement toward collaborative care models that can provide better patient care to more patients. We need people to have life-long care and access to care, but it's not all about having a family doctor.

It also needs to be a goal that the family health services that are provided are culturally safe services. Mi'kmaq communities also need access to good care, to team care. One specific example that was noted was that ensuring access to midwifery services particularly for Indigenous people who need that service can allow for births to happen in community in a culturally safe way.

We need more equitable access to family health care services and there is the potential that collaborative care models can help in addressing concerns of diversity, equity, and inclusion to ensure that all communities are receiving the care that they need. Thus, it is important to consider, as we move toward collaborative care models, how will these models serve underserved communities and rural communities? The specific collaborative care model might look different in different communities. The patient needs to be the focus in the way that collaborative health care models are developed. The focus is on the patient journey, which dictates which providers are needed to do the work in that community. Some communities will need people who focus on specific practice areas (e.g., elder care physician). Each practice will look different depending on the specific community that it is set up to serve. The focus in how the model is developed should be build/designed based on the patient journey. This is not only good for patients, but often is also appealing to physicians as a place to practice and particularly to up and coming practitioners.

Ultimately, if we're moving in the direction of a collaborative model, we must ensure that the model serves *all* of our communities.

What are the near-term steps that must be taken to set us in the right direction? What are the untapped opportunities that exist? What are the barriers that prevent us from achieving our goals and how do we overcome them?

In the near-term, we need ways to recruit more health care providers, including both physicians and other health care professionals. National licensure is one way to potentially bring additional physicians and other health care providers to Nova Scotia as it would allow providers to transition between provinces more easily. National licensure could potentially draw some physicians away from Nova Scotia to other provinces that pay higher rates, but there are other reasons, such as lifestyle, that draw physicians to Nova Scotia. In general, opening the process for recruitment so that physicians and other health professionals from other provinces or other countries can come here and practice is an important step toward providing access for all.

Ultimately, though, recruitment cannot solve the problem. There is competition between different jurisdictions to recruit healthcare workers and we need to think not only in terms of additional recruitment, but also in terms of transforming the model of care.

In both the near term and the longer term, there is a desire to move toward collaborative care models in the Maritime Provinces. The collaborative care movement is known by different names in different provinces. Nova Scotia, uses the term 'health homes' while Prince Edward Island uses 'patient medical neighborhoods'. Regardless of term, collaborative care models are generally envisioned as providing patients with a team of providers that would help to meet their primary health needs. Medical neighborhoods expands the collaborative care concept to consider other services that people might need in order to access quality health care. For example, PEI is working with libraries to provide internet access to people so that they can access virtual care and working with Access PEI to streamline the process for accessing health care as a new resident.

It was noted that there could be the potential for people to be confused by terminology. As noted above, there are different terms being used for collaborative care models which can cause confusion. There is also a very strong mental model around the need for a family physician for everyone. It was suggested that enshrining the idea that patients are cared for by teams of providers in policy could be one way to add some clarity to this issue. There is also a need for education for providers and for patients about this new model.

An important near-term step toward a collaborative care model is to ensure that health providers can practice to their full scope of practice. There are often barriers to this happening such as cultural norms and employment standards that shape what scope people are allowed to practice in, even though their professional scope of practice is more extensive. For example, many practitioners including nurses and pharmacists have a large scope of practice, but other care providers, such as family physicians, are not necessarily aware of what these practitioners can provide to patients. It is important not only to recognize the full scope of practice of each professional, but also to ask: How do we enable practitioners to practice to the fullness of their scope of practice in a collaborative way? Health professionals are taught to collaborate, but they are not necessarily taught what that means. There needs to be better education about how health professionals work together and there needs to be increased trust between providers. We have yet to achieve the level of trust between different providers that's needed for collaborative models to work.

There are other system issues that make collaboration difficult. Providers in different geographical locations might need to work together to provide good care. This raises issues with record sharing and communication. Improvements in patient records (e.g., electronic patient records; the One Patient, One Record program) and other communication improvements can help teams in different locations to work better together. Moving toward electronic records and improved virtual systems also offers opportunities for virtual collaboration between providers.

There also needs to be changes to allow for more virtual collaboration between health care providers. Currently there is no billing code for asynchronous electronic consults, which needs to change to open more possibilities for virtual collaboration between specialists and primary health providers. Family care providers are burdened by the lack of access to specialist care for their patients. Tools like virtual connection of primary care providers and specialists in Nova Scotia are important for addressing this burden.

Issues of privacy and cyber security become very important concerns for developing collaboration across locations (e.g., electronic records, electronic transfer). There may need to be legislative changes that would transfer the control of the primary care data of patients to the patients themselves, rather than to the primary care provider.

There are also challenges and barriers related to health equity in terms of making some of these changes. Some of the planning processes involved in making changes to health care rely on a very white, privileged lens. It is important that changes address all the people who are coming into the system from other backgrounds or facing other barriers including Indigenous communities, people who are homeless, people living with addiction.

What information or research do we need that we don't yet have access to? How do we access that research?

In many cases, rather than a need for new information or research in this area, it was voiced that we need better methods for sharing information and educating people. There is significant research and practice that demonstrates the value of collaborative care models, but many people remain attached to the idea of every patient having a family doctor as their primary care provider. This is shown in the way that access to health care is often discussed in terms of the people who are on the list waiting for a family physician, but it also manifests in the way that patients or health care providers might be reluctant to embrace a new model of care. In some collaborative clinics, family physicians have continued to be the most responsible provider which can result in extra work or liability for family physicians and can reduce some of the benefits of a collaborative care model. Some patients may be hesitant to move to a new model of primary care access. This presents challenges as we transition to a collaborative care model. More information about how we best engage in educational and informational campaigns so that the public and providers better understand the changes being implemented could be useful with addressing some of these challenges.

What behaviours do we have to motivate in the profession to achieve these changes? How do we motivate those changes?

Health care providers and leaders need to be open to allowing all health care providers to work to their full scope of practice. Working to the full scope of practice means a willingness to work together to provide the best patient care and requires knowledge about the scopes of practice of other health care providers. In the longer term, additional emphasis on interprofessional education is important to add to the training programs of different health care professions. In the shorter term, information needs to be shared with practicing health care professionals and health care leaders. One way to potentially do this is to share successful models of collaborative care.

For example, there's been a pilot project with mobile clinics in Nova Scotia. These mobile clinics bring interprofessional teams to provide care to communities that need care. For the health care providers and physicians involved, it has been a chance to realize what other health professionals can contribute and the care that they can provide. These teams are collaborative and interprofessional. One of the lessons learned from this project is the importance of thinking about how patients and providers navigate the system. The mobile clinic project shows that collaborative team-based health care is absolutely doable, but the navigation piece is critical. You may need to employ people who are not health professionals (such as peer counsellors/people with lived experience, people as care navigators, etc.) to help patients navigate the system.

The physicians of this province have been disenfranchised. We need to engage family doctors. Patients and policy makers alike often assume they know what family doctors do, but that is not always the case. Family doctors need to be recognized for the good work they have done and they need to be brought into the conversation about collaborative care in an effective way.

What behaviours do we have to motivate among the public to achieve these changes? How do we motivate those changes?

The public will need to be open to new models of primary health care and though collaborative care models have the potential to provide better access to care for more people, there will be hesitancy to move away from the traditional model of family physicians. Educational and informational campaigns will be needed. Engagement with patients as the changes are planned and implemented is also very important. Public consultation needs to be part of the process.

There also needs to be recognition that while some patients might embrace changes that allow them to take charge of their own health care more effectively, such as online records, online access to test results, and virtual care options, there may be other patients for whom this model does not work as well. The concern was raised that the assumptions generally made about collaborative care – such as people taking charge of their own health care – is limited and is not trauma-informed. For example, Indigenous communities are in a different position and engagement with community is important for ensuring a model of care that meets their needs.

If we were to reconvene in a year's time, how would we know that we are headed in the right direction?

There would be continued engagement and collaboration amongst healthcare leaders and decision makers to address specific barriers and continue the move toward collaborative care models. There would be increased awareness and education amongst the public and amongst providers of the benefits of moving to a collaborative care model and we would see more Atlantic Canadians with access to primary care through access to a health home.

Method

We invited leaders and decision-makers from the public health, healthcare systems, and policy in Nova Scotia. The discussion took place in-person over two sessions on June 9, 2023, each one hour long with approximately 20 total participants between the two sessions. The majority of participants selected their top two choices of three possible roundtable topics and were assigned to those roundtables accordingly. Some participants were assigned to roundtables based on availability of seats and their expertise.

This note does not attribute comments to individuals during the discussion; it merely summarizes the comments. Participants shared their observations and experiences; we did not confirm the accuracy of their comments.

Participants were asked to discuss the following questions and encouraged to speak freely during discussion:

- What are the medium-term goals (3–5 years) we are trying to achieve?
- What near-term steps must be taken to set us in the right direction? What untapped opportunities exist? What barriers prevent us from achieving our goals and how do we overcome them?
- What research do we need that we don't yet have access to? How do we access this information?
- What behaviours do we have to motivate in the profession to achieve these changes? How do we motivate these changes?
- What behaviours do we have to motivate in the public to achieve these changes? How do we motivate these changes?
- If we were to reconvene in a year's time, how would we know that we are headed in the right direction?

About the MacEachen Institute

The MacEachen Institute for Public Policy and Governance at Dalhousie University is a nationally focused, non-partisan, interdisciplinary institute designed to support the development of progressive public policy and to encourage greater citizen engagement. Constance MacIntosh, of the MacEachen Institute, was a co-organizer of this event.

Contact

For more information, contact **mipp@dal.ca**

More from the MacEachen Institute

The Institute is working to create resources and policy discussions. These include briefing notes as well as panel discussions, videos, and media commentary. You can find our **research and resources** on our website.

MacEachen Institute briefing notes on COVID-19

- Falling Through the Cracks: Long-Term Care and COVID-19
- The Road to Recovery for Atlantic Tourism
- Climate Adaptation in Nova Scotia: Overblown or Underwater?
- Race and Party Platforms in the Nova Scotia Election
- COVID-19: Leaders from the Health Community Identify Lessons from the First Wave and Concerns for the Second
- Lessons Learned from the First Wave or Lessons Merely Identified? Improving Nova Scotia and New Brunswick's health system for the second wave of COVID-19 and beyond
- Health Care Issues and Media Coverage Before and During the Pandemic
- The Economy and Media Coverage Before and During the Pandemic
- Social Justice Issues and Media Coverage Before and During the Pandemic
- Environmental Issues and Media Coverage Before and During the Pandemic
- Climate Risk Governance in Light of the COVID-19 Crisis
- Observations from Toronto's Tourism Recovery Post-SARS in 2003
- Foot and Mouth Disease in the U.K. in 2001: Observations for Policy-Makers and the Rural Tourism Sector in the age of COVID-19
- Labour Issues and COVID-19
- Quarantine and COVID-19
- People with Disabilities and COVID-19
- Nova Scotia Power and COVID-19